

Housing: Just what the doctor ordered



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Authors:

Merron Simpson
Tim Parkin
Heather Henry
Vic Rayner

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Executive Summary

We know that there are health inequalities within England. The Marmot Review¹, carried out in 2010 recognised that housing was one of the critical determinants of health. Since then, there has been a gradual awakening from both health and housing that closer working and integration can support a shared ambition around independent living and better health. However, new legislation governing the support of adults in need in England takes this assertion one step further. The statutory guidance around the implementation of the Care Act 2014 boldly asserts-

"Housing is therefore a crucial health related service which is to be integrated with care and support and health services to promote the wellbeing of adults and carers and improve the quality of services offered"

Section 15.48

This guide is designed to support housing and housing support providers to make this statement a reality. In order to make this happen, Sitra and the NHS Alliance have worked together to develop this resource which will support the housing sector in taking forward its work with Clinical Commissioning Groups. We know from our work with our members that there is huge ambition for this connection, from both sides of the fence, but moving from rhetoric to reality is challenging. Therefore this report is jammed full of guidance and insights into the pressures and challenges facing CCGs, case studies, checklists and ideas for action. The report also provides a detailed overview of the key legislative and policy changes, to ensure that those working in housing and housing support fully understand the context of their potential CCG partners.

The partnership between Sitra and the NHS Alliance ensures that the information included within the resource stems from a concrete understanding of the health and housing sectors.

By the end of this report you will be able to answer the following questions:

Preparing The Ground:

Have you:

1. Identified early adopters and allies? ✓
2. A clear understanding about what matters to your CCG? ✓
3. Worked out who they talk to? ✓
4. Decided whether to make a collective approach, and if so, with whom? ✓
5. Developed a clear understanding of how your work and priorities match with CCG priorities. ✓
6. Identified some big facts about your organisation that will grab their attention? ✓
7. Thought of a good way to get your message across quickly and effectively? ✓
8. Identified one or more 'hooks' that will obviously address an issue for them in a timely way? ✓

Defining and making a successful offer

1. Have you developed an offer around something they have shown significant interest in? ✓
2. Are you certain about the fit with your organisation and about your ability to deliver? ✓
3. Can you evidence the outcome in terms the CCG will accept? If not, how will you fill the evidence gap? ✓
4. Can you articulate, specifically, what it is you need them to do? ✓
5. Are you making a specific offer, or do you want health partners to co-create with you? ✓
If the latter, who are the health partners and what is the ask?
6. Have you considered all the different sources of funding for your project, including from other partners i.e. not just CCG monies? ✓
7. Have you been trying to make a case for some time and not getting anywhere? Maybe it's time to step back. ✓
8. Do you have a strategy for maintaining their interest in the longer term? ✓

¹ Fair Society, Healthy Lives, The Marmot Review, 2010 <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

Section 1:

Introduction

What's this report all about?

This is a handbook to guide housing and housing support organisations through the process of developing a relationship with Clinical Commissioning Groups. Reference is also made to NHS providers, especially GPs. They deserve specific attention because many of them are unaware of some of the roles housing and housing support can play in keeping their patients well and the consequences for those of their patients who live in unsuitable environments.

The information and insights contained in this handbook come from several sources and reflect both the direct experiences of the authors and of people they have had contact with. Some of the insights were gained from direct engagement with a number of CCGs that engaged with this project. These CCGs were approached with an offer of assistance to connect with housing partners. Some were successful, some less so, but in every instance the authors sought to reflect on their experiences and to capture the learning about the process of engagement within this document.

How to use this report

This report is intended to help you think strategically about how to approach your local CCG, and to provide you with some detailed guidance on 'how to' and 'what works'. As you use the resource, you will find that it:

- Introduces a range of high impact actions / top tips to help develop a better relationship with health services
- provides a method to work through – but no 'right' answer
- checklists to make sure you've prepared as well as possible
- provides background and insights
- identified barriers and challenges you are likely to come across

It also gives you some background as to how it can work in practice. It gives an overview of pilot work carried out by Sitra and NHS Alliance, showing the opportunities and the very real challenge of seeking to work directly with Clinical Commissioning Groups.

The report has been written with housing practitioners in mind, but we hope that there are ideas and resources that you may wish to share with colleagues in your CCG.

Section 2

Setting the Scene – Culture and policy

The prevailing culture of the NHS

Biomedical models dominate thinking across primary care and health systems.

It is widely expected that health professionals are more inclined to consider a drugs or treatment based solution to their patients' health issues than a social or psychological solution. Whilst this may not be the case for some professionals, it is generally accepted that as a professional body, health practitioners prefer evidence-based solutions. This reflects the training of GPs and specialist health professionals and can limit the extent to which the NHS looks outside itself for answers to deficits in the health system and directions for the future of the health service.

There are a few well developed examples of general practice that operate along psycho-social models, which adopt a more holistic approach to diagnosis and treatment, based on treating the person, not just the symptoms. These include the Colm Valley Practice in Devon² and Bromley-by-Bow Centre in Tower Hamlets³, but these are the exception rather than the rule. Local health systems are starting to emerge that are more people-centred, and that seek to integrate both health and social care around the needs and ambitions of patients and their carers. So far, they tend to be focused on people living with long term conditions. North West London Whole Systems Integrated Care is one example:⁴

As an overview, an animation from Royal College of General Practitioners explains the type of 'Collaborative Care and Support Planning' that GPs are being urged to adopt:⁵

The prevailing understanding of 'housing'

Housing, as a system, is difficult for health professionals to understand.

Domiciliary physiotherapists, occupational therapists, integrated rehabilitation teams and most community nurses have insights into patients' living conditions. GPs also have some understanding through home visits. However, few health professionals have first-hand experience of being a customer of a housing or housing support organisation or have ever visited a housing office. Many have no mental picture or points of reference to the 'world of housing' and have little idea of the concept of the breadth of work that housing organisations do. In contrast, most if not all, housing professionals will have first-hand experience of the health system.

It can be particularly difficult for health professionals in secondary care to understand why housing and housing support organisations are interested in their patients' health and wellbeing. This lack of awareness means they tend not to be able to locate housing as distinct from either the wider statutory, or the charity and voluntary sector.

GPs and community nurses who have practiced in an area for many years will know more, particularly if they have been involved in regeneration programmes in the past that contained a health element. They often have a greater appreciation of the health impacts of poor housing and environments, and the potential for physical and community regeneration to deliver improvements in their patients' health and wellbeing. GPs who have championed the housing needs of some of their patients will also have a greater understanding of the systems for accessing suitable housing, for example.

GPs who are experiencing increasing demands on their services, may view connecting with housing as an additional burden, and without the clear articulation of the effects of housing and housing support on people's health, they are unlikely to seek collaboration with housing organisations.

Most GPs feel over-burdened by the demands on their service and sometimes imagine that 'housing' is another thing they are being asked to do. They don't necessarily see the benefits – either to themselves or to their patients – of developing a constructive collaborative relationship with housing organisations.

² Culm Valley Integrated Centre for Health: <http://www.collegesurgery.org.uk/>

³ Bromley-by-Bow Centre: <http://www.bbbc.org.uk/>

⁴ <http://integration.healthiernorthwestlondon.nhs.uk/>

⁵ https://www.youtube.com/watch?v=2RV2lek-JXQ&feature=player_embedded

Recent developments in housing and health

Things are starting to change.

While the main focus has been on integration of health and social care, there are also new directives for the NHS relating to housing: Full details of all the policy changes and their connection to housing can be found in Appendix 1.

- The **Care Act 2014** states that “the provision of housing accommodation is a health-related provision” in relation to the duty on the NHS, clinical commissioning groups and local authorities to promote integration of care and support, health and health-related provision.
- **NICE Guidance**⁶ on ‘Excess winter deaths and morbidity and the health risks associated with cold home’ published in March 2015 includes recommendations for a health and housing referral service – to identify people at risk of ill health from living in a cold home and provide tailored solutions accessed through a single point of contact. It places a requirement for the NHS to work with others beyond its boundaries to address the problem of deaths caused by cold homes, and recommends integrated teams. It also contains provisions on discharging vulnerable people from health or social care settings to a warm home.
- **Memorandum of Understanding** to support joint action on improving health through the home⁷. This key document lays out the rationale for health and housing to work together, and is accompanied by an action plan signed up to by a range of partners including NHS England, Public Health England, Department of Health, Sitra and other health and housing organisations.
- **The NHS Five Year Forward View**⁸ recommends ‘New Models of Care’ to create a health service that has prevention at its core and is sustainable in the long term. This new long-term vision, coupled with the pain of unprecedented pressure on NHS, is causing CCGs and others to look more widely for solutions.

The NHS Alliance has created a web-based resource called Housing for Health⁹ for strategic leads in health and clinical commissioning. It provides information about and insights into housing, and what might be possible through housing-health collaborations, as health partners develop new models of care in response to the Five Year Forward View.

The Opportunities for Housing – Understanding the drivers for CCGs

The main opportunities for connecting and collaborating with CCGs derive from the changes taking place through the Five Year Forward View and the new models of care. Currently, these plans run the risk of disrupting existing networks and relationships and tying up resources and time and not actually result in systematic substantial improvements to patient care as envisaged. Housing can help to move NHS partners into new ways of thinking and acting via effective partnership. The most straightforward way ‘in’ might therefore be to focus in on a few key issues that are top priority for health including:

- social prescribing from GP surgery – which must contain housing and housing options elements
- hospital discharge schemes
- emergency admission avoidance schemes
- addressing cold homes (in private housing)
- co-location of health within multi-disciplinary (primary care) teams
- new premises for health and community hubs
- community development
- community self-management
- preventative approaches generally, that can be demonstrated to reduce demand on the NHS

It is important for housing to work with others in the community, rather than competing with them (unless within a contract tender situation), in order to bring the most appropriate skills and capacity to the table.

⁶ NICE Guidance: Excess winter deaths and morbidity and the health risks associated with cold homes: <https://www.nice.org.uk/guidance/ng6>

⁷ Memorandum of Understanding to support joint action on improving health through the home: <http://www.sitra.org/documents/mou-health-through-the-home/?preview=true>

⁸ NHS Five Year Forward View: <http://www.england.nhs.uk/ourwork/futurenhs/>

⁹ NHS Alliance Housing for Health resource: www.housingforhealth.net/lic_health_workforce/rsph_widerworkforce_report_final.pdf

The Future

The machinery for delivering health and social care is complex and evolving. The prospect of further devolution to regions and cities in England is likely to change the scale of integrated working. As an early example, high level agreement has been reached in Greater Manchester to create a coordinated approach to health and social care across ten local authorities and 12 Clinical Commissioning Groups covering some £6billion of annual expenditure. The desire to achieve closer integration is likely to increase, both at the strategic level and on the ground where support is actually provided to individuals. This is because integration is seen as a way of tackling the continued pressures faced by the NHS and local authorities from the combined effect of increased demands from people living longer, with the associated increase in the prevalence of people with long term and multiple conditions (co-morbidity) such as dementia, together with increased costs of treatment from new technology and medicines.

For many of the changes taking place the housing sector can and are making an important contribution. That the Care Act recognises this is to be welcomed. The role of housing features much less in key health documents such as the Five Year Forward View, although it is implied. In 2014 the Memorandum to support Joint Action on improving health through the home¹⁰ recognises the importance of housing and sets out some broad principles for joint working to deliver better health and wellbeing outcomes. This is an important signal that there is a real opportunity for housing to 'step up to the mark'.

Full details of policy directives cited and their implications for housing can be found in Appendix 1.



¹⁰ Memorandum of Understanding to support joint action on improving health through the home: <http://www.sitra.org/documents/mou-health-through-the-home/?preview=true>

Section 3:

Preparing the ground, making an approach

Housing and housing support organisations have made many attempts to attract the attention of CCGs, but still relatively few have been commissioned by them. To be successful requires both (a) the right approach and (b) the right offer. This section focuses on the first of these – your approach.

It is important to plan your approach carefully to hit home the relevance of what you can do to help CCGs to meet their priorities. You stand a much greater chance of success if you are well prepared and have a strategy in place for securing their interest in the immediate, medium and long term. You don't need to have a fully-formed offer to present at the first meeting but you do need some credible ideas that have been thought through sufficiently well to convince them that you can help them.

Preparation

Before approaching a CCG, you will need to do some homework to help you to start to think from the perspective of your CCG. The main purpose of this preparation is to consider what it is that might interest them in having a meeting with you.

Things you might want to consider are:

Identifying early clinician adopters and allies: Early adopters who are influential and carry the confidence of peers are essential. If they understand the social model of health as well as a clinical one and are clearly 'value driven', then they may be prepared to champion the involvement of housing in CCG commissioning and provision. They may even enable housing organisations to demonstrate success via piloting and roll out.

Identifying these senior clinicians can be done in a number of ways. These include through:

- personal contacts
- introductions via a third party
- allies such as the Director for Public Health
- other Health and Wellbeing Board members
- observing interactions and exchanges in meetings
- direct enquiries of CCG personnel
- examination of CCG board papers and reports
- press releases/media coverage
- tweets from local clinicians
- national organisations, such as Sitra and NHS Alliance

Having an introduction from a familiar and valid source – someone they trust to give them useful information and connections – is very important.

Understand what matters to them: If you can demonstrate that you understand what is top of their minds – their pressures and priorities – you will have more success in engaging them. The NHS Five Year Forward View and the NICE cold homes guidance should matter to them. Other sources of information you could look at to deduce this include:

- The CCG's website: evidence of what they're engaged in through partnerships, publications, projects, news releases
- Board Papers (all available on their websites) to get up-to-date on key issues and look more deeply into how they're thinking about specific issues
- Evidence of how well they connect into the work of the Health and Wellbeing Board
- The CCG Plan will give you an overview of their priorities, but things may have moved on for them since it was written, so don't rely on it to give you all the information you need.

Find out who they're talking to: Through the process of understanding what matters to them, you should be able to build up a picture of who it is that they are talking to. This should help you to identify potential allies as well as give you an idea of the kind of vision they're shaping.

Decide whether this is a collective or an individual approach: The possibilities are:

- collective – with other housing providers in a locality
- collective – with other local (non-housing) provider partners
- individual – just your organisation

CCGs operate over a defined geographical area and find it very difficult indeed to work out how to engage with the myriad of housing providers on their doorstep. Not only this, but they will find it even more difficult to understand your spread, specialisms and the non-housing roles you might be able to play. Either they will not appreciate that there are many housing organisations which could help them in different ways, and will expect to have just one conversation, or they will feel overwhelmed by the task and not know where to start in terms of engaging with housing organisations.

One senior GP lead recently made this comment about housing:

“Not knowing how to navigate the maze puts me off attempting to connect”

You should not underestimate the peculiarity in the way that housing is organised and the difficulty that having many housing providers, each with different strengths and specialisms, presents to health professionals.

Making a collective approach with other housing organisations

Making a joint approach together with other housing providers in your locality can work very well especially if you have a history of working together, if you have different characters or specialisms or if you cover different geographical areas. Local authorities, Arms Length Management Organisations (ALMOs) and local Large Scale Voluntary Transfer (LSVT) housing associations are well positioned to bring local partners together to negotiate a joint approach.

For example, in Leicestershire, seven District Councils, most of whom own and manage housing, worked together on a collective offer to one Health and Wellbeing Board and two CCGs. Two of their key project offers have been taken up by the CCG and are now being implemented across the County.

Birmingham City Council has set up ten housing panels, one for each district, and is exploring how all the housing providers in those districts – including private landlords, housing associations and the council as landlord – can connect more fully with the CCG. These panels will be key to taking forward work with Birmingham South Central CCG.

CCGs appreciate a collective approach because it enables them to have a single conversation with all the key housing providers, rather than having to have several conversations with different providers which may not lead them into partnership with the most appropriate organisations. It is also an efficient way of getting maximum exposure of the CCG both to those organisations that house some of their GP members' patients and the range of specialisms that housing organisations collectively can offer.

The downsides of this approach is that it takes some effort to coordinate and can get bogged down if partners aren't fully engaged in the endeavour. It needs a dedicated leader to keep the momentum across the group.

A consortia approach

Housing organisations can play lead roles in local bidding consortia with other community-based organisations that have particular specialisms. This can work very well once the consortia is mature because it allows organisations to play to their strengths; they can contribute to bids and deliver across a range of projects with a different mix of members being involved on each occasion.

An example of this is the Healthy Living Partnership¹¹, a partnership between the Accord Group, Black Country Housing Group, Murray Hall Community Trust and The Kaleidoscope Plus Group that bids for and delivers contracts.

Accountable Lead Provider

The relatively strong financial capacity and contractual know-how of housing and housing support organisations coupled with the valuable specialisms of the smaller organisations can provide a very strong and attractive offer to commissioners. This sort of consortium is familiar to commissioners within the NHS and 'Accountable Lead Provider' is the term used for the dominant organisation within the consortia.

¹¹ Healthy Living Partnership: <http://www.healthforliving.org.uk/>

Alliance Contracting

There is an increasing understanding of the role that Alliance Contracting might play in the commissioning of health and social care services. The Association of Chief Executives of Voluntary Organisations (ACEVO) has provided detailed guidance on the area in their recent report, Alliance Contracting: Building new collaborations to deliver better healthcare¹². Recent work by Sitra has highlighted how this approach can be applied to housing services¹³.

Making an individual offer

If your offer is fairly unique, you are able to provide the service on a significant scale across the entire population or you are one of relatively few housing organisations locally that are doing work on that particular aspect of health and wellbeing, then there's nothing to stop you from approaching the CCG as an individual organisation. This has worked for many organisations and is one way of simplifying the communications task. Some Housing Associations and housing support providers may also see it as a way of diversifying their contract base.

There are drawbacks, however, to behaving too competitively:

- you may not necessarily be the best organisation to lead locally on a particular initiative, but your CCG won't necessarily know that
- you may be limiting residents' access to the service you're offering, especially if you concentrate mainly on your own residents
- developing an exclusive bilateral relationship can reduce the scope for others to get an audience with the CCG and this could limit their appreciation of what housing organisations can do.

Even if you are a clear lead in a particular area, there may be wider benefits to promoting housing collectively or at least coordinating your work with others around different specialisms.

Cross-match your work and priorities against CCG priorities: It is not always possible to identify a hook early on. You may need to do a more comprehensive piece of work to see where the biggest gaps are for them, and match that with what you believe you are able to do.

Cross-matching how what you do and your priorities against your CCG priorities is an important exercise because it helps you to crystallise where the overlaps lie and to think about how what you do might be reworked to support their priorities. Matching what your organisation is already offering and may be able to offer in the future, against the priorities in each of the CCG Plan, Health and Wellbeing Strategy and any other local health strategies, will help you to see where what you do or might do fits most closely with what they want to achieve.

Securing their interest at first meeting

Choose some 'big facts' about your organisation or partnership: Don't start by telling them all about what your organisation does – it will take too long. Instead, select two or three facts that you think would grab their attention and find a way to bring those into the conversation early on. Big facts might be, for example:

- the number and proportion of their patients you could reach through a local campaign
- potential savings to the CCG if they would work with you on a specific project
- how much you know about their patients that the CCG doesn't know and how this knowledge could be used to improve health

It might also include a compelling story that demonstrates unequivocally the value of what you did for an individual and how that could be translated into savings to the NHS.

Be succinct: Work out your 'elevator pitch'. Clinicians tend to be quite focused and will take in information quickly and make speedy judgements. They will be more interested in what you can do for them and their patients than in your organisation and what it is like. As one CCG Chief Clinical Officer put it:

"I don't want motherhood and apple pie ... words + a graph is good ... then "who are you?""

Sometimes, use of short film clips or animations can help to get your message across. Useful video clips include the Placeshapers Health and Housing animation¹⁴.

Skills for Care have also developed a number of key videos exploring the connections between housing, health and social care¹⁵.

¹² ACEVO Alliance Contracting: Building new collaborations to deliver better healthcare

¹³ Alliance contracting - www.sitra.org

¹⁴ Placeshapers health and housing animation: <https://www.youtube.com/watch?v=T-od5iXaDGQ>

¹⁵ Skills for Care – link to videos: <http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-integration/Social-care-and-housing.aspx>

Find a 'hook': Finding the right hook is probably the single most important thing you need to do to get the attention of your CCG. This means going further than just understanding what matters to them, it means working out what, specifically, they will find irresistible. A good 'hook' is a single idea that will solve the issue that is top of their mind. If you can identify, and find a way to help them solve one or more of their 'wicked issues', then this is likely to provide you with your hook. You might want to have in mind two or three potential 'hooks' to test during the conversation, to see which gets the strongest reaction.

Manage your expectations: Getting a half hour meeting at their premises might be relatively straightforward, but requiring their presence at a full-day session about housing and health may not be realistic even after securing their interest.

However you gather your information, make sure you go into your initial meeting with two or three compelling pieces of information and strong ideas at the very least.

Pathways Community Interest Company webinar on engaging GP practices

The Pathways CIC recently ran a webinar for community-based organisations on the topic of engaging GPs. If your proposal to a CCG involves engaging GPs (for example by prescribing home improvements) then you need to be aware of how to do this.

It can be found here:

<http://www.sitra.org/policy-good-practice/housing-for-health/pathways-gp-engagement-webinar>

The main points are:

- Understand what it's like being a GP in the present moment, the pressures and anxieties of GPs
- Do your homework – find out about the particular practice you're trying to engage. Practices vary enormously in their style and so do the personalities of the people running them
- Identify channels of communication – emails, letters, leaflets typically don't work, and Practice Managers and receptionists will screen out information they don't think is directly useful to the GP. Cold calling almost never works. Instead, draw on your networks to identify and be introduced to the right person who needs to be a GP or CCG lead
- Don't expect to get a long meeting – 30 minutes is good and should be sufficient to get the message across, but equally you could get 10 minutes and this could be just as effective if you are well prepared
- Deliver simple, short, crisp proposals in the way that they will see it, stating how it will make GP's lives easier and patients' lives better. Get straight to the point, cut out the management speak, use simple English
- Make sure any written communication is less than one page of A4 and use videos, case studies and storytelling to get your message across
- Be persistent – a lack of response isn't necessarily a sign of disinterest, it is more often a sign of intense busyness. Keep on repeating your simple, crisp messages
- Under promise and over deliver
- Commit to building the relationship – deliver constant and consistent communications and make sure you regularly feedback to the GP or CCG.

Successfully engaging a CCG: a case study

The Chair of this CCG was invited to participate in helping prepare evidence for this report following two previous communications. The initial introduction was made through a locally based third party who is known and trusted by the CCG Chair. A 30 minute telephone interview was held and this established an initial connection.

It was noted during the interview that the CCG chair was keen to expand the work of the CCG beyond the purely medical model and to pay much more attention to influencing the wider determinants of health. He understood housing to be a key factor in this. He was also open to the idea of roles that housing organisations might play in reducing pressure on the NHS through addressing both health inequalities and the non-medical needs of individual people before they present at the surgery or at A&E.

The Chair agreed to be involved, based on his assessment that the project was timely and would be valuable. The project was deemed to be both the right one and timely. The Chair later reflected on what it was that drew his attention and led to successful engagement, saying *"It was the right bait, and the right fish"*.

It should be noted that this was the third attempt to connect with a CCG from this region. Of the two that were approached before this one, one declined to be involved on the grounds that they had already committed to moving forward with a housing-related project and they didn't have the capacity to take on another. The other did not give a reason.

CHECKLIST Preparing the ground

Have you:

1. Identified early adopters and allies?
2. A clear understanding about what matters to your CCG?
3. Worked out who they talk to?
4. Decided whether to make a collective approach, and if so, with whom?
5. Developed a clear understanding of how your work and priorities match with CCG priorities
6. Identified some big facts about your organisation that will grab their attention?
7. Thought of a good way to get your message across quickly and effectively?
8. Identified one or more 'hook' that will clearly address an issue for them in a timely way?



Section 4

Defining and making a successful offer

There is no 'right' way to go about making your offer and no single formula for success. As this project found, there are several reasons why you may not be successful in connecting with your CCG and it is important that you learn from those experiences.

We have found that three things are key:

1. relevance of your 'offer' to the CCG
2. timing in relation to when their priorities are most pressing, and
3. their capacity to act.

Getting these three elements right is a pre-condition of success, but it doesn't guarantee success. This section explores some of the other factors that you might want to consider when defining and making your offer.

Defining and making your offer

Quick wins: If you have already had a conversation with the CCG and found that they responded well to one or other of your ideas, that you had identified a 'hook', then consider building your initial offer around that. This is a short cut to identifying a quick win. Having success in one area will help you to build the relationship and your credibility, and should pave the way for other joint initiatives later on.

Be flexible and realistic: When you talk to your CCG, they may focus narrowly on what you are actually doing right now. It is important to impress on them that you can do other things too, but that you need to develop this through dialogue with them or with the GP practice groupings, rather than entirely independently.

In negotiating,

- be sure you know what you want out of the arrangement
- where the wins are for you
- what your limits are – scope and capability
- under promise and over deliver is best

Evidence outcomes: You should present whatever evidence is available in numeric or graphical form where possible – this is the norm for medically trained professionals. A 'control' group is often requested by clinicians, to prove the causality between health improvements and the intervention. Ideally, you will already be able to demonstrate outcomes, but if you don't have strong evidence available, then your project plan must show how you intend to collect robust data to demonstrate' for instance:

- reduction in GP appointments
- avoiding admissions to hospital
- reducing prescribing costs
- (re)admission avoidance
- valid quality of life measures, (QALYs) or wellbeing measures such as the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS).

In truth, clinicians are influenced by both 'head' (data) and 'heart' (case study or storytelling). They are particularly interested in hearing success stories relating to their own patients. Ultimately, housing organisations need to be able to satisfy both although sometimes clinicians may be persuaded to trial a new way of delivering a service if their intuition tells them it is worth doing. Securing an evaluation by an academic institution is one way of ensuring credibility, as evidenced by recent work on connecting health and housing carried out by Family Mosaic¹⁶. Alternatively, you could ask your CCG to advise on the evaluation or to do it for you. You could present this as an opportunity to undertake a clinical audit for which GPs for example could claim clinical professional development evidence that might help with the revalidation requirements of their professional body, the General Medical Council.

Identify, specifically, what it is you need them to do and negotiate: It is highly likely that you need either the CCG or the GPs to do something to make it work, which might include money, GP referrals, or releasing community-level data that they hold. Make sure you have identified exactly what it is you need from them and that you communicate this clearly to them. While you need to enter discussions through the portal of what is important to them, you need to be prepared to present and to do a deal. They will appreciate clarity in the negotiation.

¹⁶ <http://www.familymosaic.co.uk/news/129/index.html>

Making a specific offer vs coproducing with your CCG or GPs

Specific offer

In the main, having a specific and well thought through offer that meets a specific need in a timely way and that comes with an evidence base is most likely to be received well by CCGs.

The timeliness may well be judged in reference to national health documents and programmes. So, a specific initiative to provide an emergency response and home treatment service for people who fall in their homes may be seen by the CCG as a timely solution to address the requirements of the Better Care Fund. In another example, a specific initiative that enables GPs to prescribe measures that improve the heating of people's homes might be seen as a useful part of the response to the recent NICE guidance on cold homes.

Alternatively, the timeliness might be judged by reference to local health matters, illnesses or priorities which can be found in the CCG Plan. So, you might want to develop an offer to address a particular illness that you know is prevalent in the locality and that puts pressure on the NHS. This might be diabetes or Chronic Obstructive Pulmonary Disease (COPD), for example, or it might relate to an issue that has been articulated more specifically such as 'the high incidence in hospital admissions among children with asthma'.

Specific offers of this kind are simple to understand and meet an immediate and obvious need. When doing this, you need to be sure that you have taken note of the available evidence relating to the disease via a search of NICE guidance and to make sure your initiative really is going to go some way to addressing it.

Coproducing initiatives with your CCG or GPs

There are some instances in which a specific offer may not be appropriate. For example, if you don't have sufficient information or evidence on which to develop an initiative that addresses the problem directly or if the solution requires a partnership between your organisation and your health partners.

To be successful, you need to have a compelling proposition that will win over your health colleagues and persuade them to coproduce. This means being very specific about what you are aiming to achieve and how it will help them to address an issue that is top of their minds.

In some instances where relationships between housing and health organisations are mature, a 'big bang' approach may be appropriate, in other instances, suggesting small pilots to test ideas may be better. Reflecting on the list of drivers listed in Section 2 may give you a clearer picture of the level and scale of joint project that might be successful in the first instance.

Getting buy-in and ownership

The strongest sign that you have the support of your CCG and health colleagues is if they are prepared to fund or part fund your initiative. However, you should not go into discussions focusing on the money, which will not usually go down well, but on the participation of health partners. Be realistic and specific about the wins for your organisation and the wins for NHS and negotiate accordingly. Consider involving other partners who you think might have an interest in it.

There are many health funds so there are several places to go to look for financial support. These include:

- CCG monies
- Money passed from CCGs to GP Networks and Federations
- Public health
- Better Care Funds
- National initiatives e.g. Prime Minister's Challenge Funds
- Innovation Funds locally and nationally e.g. Health Foundation
- Social enterprise funds e.g. NESTA

Recognising when it's time to step back

If, despite trying several different approaches, you are not making good progress with your CCG or GP groupings, then it might be time to take a step back. This doesn't mean giving up but it does mean giving space and time for the CCG to develop its thinking while remaining present, available and in touch with their thinking. CCGs and GPs are much more likely to be prepared to work with people and organisations they are familiar with. But when it comes to getting a project off the ground, timing is everything. It's quite likely that later down the line, a specific opportunity will arise and provide the route into connecting with your CCG.

Some examples of when to approach include:

- the moment when new national priorities are kicking in
- at the end of summer when they are more likely to be looking to sign off solutions to the annual 'winter pressures' crisis
- development of new housing stock

Maintaining their interest in the longer term

Even if you had success in accessing the CCG or GP network in your local area, you need a strategy to maintain your partnership in the long term. Here are some suggestions:

Invite a CCG officer or clinical lead to join your board: Housing organisations that have CCG representation on their board, or who have a seat on the local CCG Board are often the most successful in maintaining collaborations. The insights they gain make it possible for them to see how the housing association might develop its work to support that of the CCG and vice versa. Conflicts of interest may arise but there are ways of dealing with them.

Co-locate staff members with their Multi-Disciplinary Teams (MDT): If you have already been co-opted onto a Multi-Disciplinary Team, then this should provide a good platform for further engagement on specific issues. Make sure that you are fully integrated and, especially if your teams are not co-located, that you are receiving all the papers and being invited to all the meetings.

Reinforce the connection via patients who are your tenants and staff: There is the potential to develop closer links and understanding with CCGs through tenants and staff who may be engaged with patient participation groups, which are a highly permeable part of the NHS. As an example New Charter Housing is developing a strong connection to a group of seven practices that are operating as a federation. The journey of collaboration started through staff visiting their GP and talking about the work they were involved in, during their consultation. The GPs showed an interest and this provided an opportunity for an Executive Director to ask for an audience with the Federation to explain the work more fully. Since New Charter is the third largest employer in Tameside, the staff-GP link is an obvious link to develop.

Put housing on the map: Providing the CCG with a map of your properties that fall within their boundary can help the CCG to see the overlap geographically. The anonymised datasets and tenant profiles that you keep might also provide them with additional information on the demographics and circumstance of their patient population. An overview of this may help to develop and consolidate the relationship, and identify areas of shared concern or activity. It will also be helpful to highlight on the map where you are undertaking particular activities such as financial inclusion work or community events may help them to get a better picture of what you do and the potential for collaboration.

Contribute to health sector education and development: GPs – and in the near future, nurses have to undergo revalidation to remain on their professional register. They have a requirement to demonstrate continuous professional development, which for GPs involves having to undertake 50 'credits' of development per year. There is a comprehensive Royal College of General Practitioner (RCGP) guide to GP revalidation and the credit system¹⁷. Housing organisations can influence GPs by providing educational content that is covered in the RCGP guidance in the form of practice development, audit or case study sections. For example, if you were to co-locate a housing officer within a GP surgery, then that would enable the GPs leading the work to gain credits in the form of practice development.

If a housing or housing support organisation feels that it wants to influence general practice via the provision of public health training the key contact would be the Director of Postgraduate General Practice Education based in the relevant regional branch of Health Education England.

Protected Learning Time (PLT). Many CCGs support GP teams locally to come together (with clinical cover from out of hours providers) to learn and update their clinical skills. Housing organisations may be able to use this opportunity to 'teach' GPs and their staff about for example, discussing the impact of housing on patients' health, for example the link between the home environment and respiratory conditions or mental health. It is worth contacting the CCG and asking if there is a PLT co-ordinator and how to get on the agenda to discuss 'public health and housing'. Alternatively as part of commissioning arrangements, cluster meetings of GPs involved in commissioning may also be an appropriate place. This may be advantageous, if your organisation only covers a certain geography and not the whole of the CCG footprint.

¹⁷ RCGP Guide to GP revalidation and credit system <http://www.rcgp.org.uk/courses-and-events/cpd-credits-and-appraisal.aspx>

In workforce planning, the key contacts are the Local Education and Training Boards or (LETBs). Their core purpose is to lead planning and education commissioning; ensure security of supply of the local health and care workforce; and support national workforce priorities set by Health Education England. So, for example, a successful initiative in one town around the skill mixing of housing and health personnel might be drawn to the attention of a local LETB with the aim of adoption and spread.

Bringing the offer to life: pilot feedback

In researching this work, Sitra and NHS Alliance spent some of the time working directly with CCGs and housing providers. The process that was established with the CCGs reflects our learning across the report. The pen pictures of the case studies outlined below give some insight into the approaches taken. Two of the projects went through to completion, however, two of them were impacted at different stages by the very issues described within the report, including time commitments, change of personnel and competing priorities.

The initial offer made to each CCG was very open. We invited the CCGs to articulate the focus they would like the project to take, all four areas came up with a suggested focus for the work and we then devised a project plan based on this. In every instance, we proposed that an event or seminar involving both housing and health partners would provide a useful way of getting the right partners together and should be a part of the project. The CCG's have been anonymized in line with the wishes of the pilot participants.

CCG A The initial approach was made to the CCG chairman, who had previously worked with one of the authors of this document on other housing issues. This successful existing relationship gave credibility and an immediate reply. There is a long history of joint working between the NHS and the council in this borough, which was amply demonstrated. A key contact name was agreed with the director of public health in the council.

It took many months however to agree the focus of the health and housing work through which to learn about the nature of the relationship for this report. Much of this was down to workload and gaining the agreement of other partners outside this close relationship.

The key levers for engagement and action were:

- The recent publication of the NICE cold homes guidance¹⁸: a clear 'how to' guide
- Concern from CCG commissioners on the level of admissions/readmissions for childhood asthma: each admission costs £773
- Childhood asthma admissions (particularly in babies) from the disadvantaged community nearest to the local hospital was a particular problem
- Benchmarking demonstrated that this region experienced the highest rates of hospital admission and was climbing, whilst other regions were falling
- The CCG had received presentations, via their strategic clinical network for child and maternal health about the NICE estimates¹⁹ (page 7) of the net savings per 100,000 population if clinical guidance is followed is between £67-100k, but the idea of working with and through homes to address parental knowledge and concerns and to identify the non-clinical aspects of asthma (i.e. cold damp homes or fuel poverty) had not been considered
- Successful initiatives, involving other CCGs were brought to their attention including Gentoo Housing's boilers on prescription scheme²⁰.

Key Learning points:

- Previous successful relationships are a way in
- Engagement takes a lot longer than you think, but don't give up
- Start with the immediate concern of the CCG or a relevant clinical network – in this case childhood asthma admissions and work backwards to what housing can do to help
- Point to evidence with financial outcomes and pair CCGs with other CCGs who have had success
- Point to step by step guides such as NICE guidance so partners don't re-invent the wheel

CCG B – The focus of this project was on keeping people well in the community and requiring less intensive health treatment from either their GP or the hospital. The CCG has committed to the Multi-Speciality Community Provider model (MCP) proposed as part of the NHS Forward View (see Appendix 1) and they saw this offer from Sitra/ NHS Alliance as a vehicle to enable them to take steps towards adopting the MCP model. They were keen to go

¹⁸ NICE Guidance: Excess winter deaths and morbidity and the health risks associated with cold homes: <https://www.nice.org.uk/guidance/ng6>

¹⁹ <http://www.nice.org.uk/guidance/qs25/resources/qs25-asthma-nice-support-for-commissioners-and-others2>

²⁰ <http://www.gentoo-group.com/news/gentoo-group-launch-boiler-on-prescription-pilot/>

beyond the immediate focus of the Better Care Fund (BCF), but felt that it would also support their work on the BCF (see Appendix 1 for explanation).

At the first meeting with the CCG Chair, an outline project plan was proposed. This had been drawn up in the knowledge that there had been scant communication between local housing providers and the CCG and also the knowledge that the CCG was thinking quite broadly about how to secure a more preventative approach to health and wellbeing in the future. Because the CCG was close to the start of this journey, and also quite keen to go on it, the decision was made to take a collective approach to introducing the CCG to local housing partners.

The project plan outline comprised:

1. An exercise to (1) map different housing organisations' properties within the CCG area and to (2) identify health and wellbeing services they are already offering, and where
2. A facilitated one day event involving key CCG personnel and housing organisations to explore synergies and potential relating to the Better Care Fund, in the short term, and the wider determinants of health, in the longer term – and to identify what needs to happen to secure effective partnerships between housing, the CCG, other partners (e.g. GP Networks).
3. Work following the event to:
 - capture information from the event and distil into a useful form for (1) CCG and (2) housing organisations to draw on
 - secure a means for the relationships to be managed and developed
4. Identify 'next steps' for the CCG to take the partnership with housing forward.

Key Learning points:

- CCGs are relatively new bodies, with new governance structures in place. This project recognised this potential to broker the relationship with a new set of partners, and the CCG was willing to engage on that basis.
- The project focussed on high level priorities including prevention and bringing care closer to home. These broad topics were priorities for both the CCG in their commitments towards Five Year Forward View and The Care Act 2014, and the housing providers in relation to their commitment to tenants and residents. The opportunity to address shared priorities created an open and productive environment.
- The resource offered by the NHS Alliance to coordinate meetings, provide follow up notes and chase actions was critical in keeping the project on track. Collective approaches need coordination.

CCG C – This CCG identified that it wanted support in one specific area of its patch. It wanted to use the Better Care Fund as a primary document to drive forward involving housing in a broader prevention agenda focused on improving health outcomes in this specific neighbourhood. A core offer was developed to support the ambitions of the Better Care Fund plan for 2015-16 which outlined a set of significant challenges facing the locality and this work may help support an exchange of information, and greater awareness on both the housing and health side around areas of common interest and activity. Potential challenges which might be supported by joint working include:

- Timely provision of equipment to keep patients at home
- Higher than desired number of patients admitted to acute hospitals for end of life care
- Insufficient level of capacity outside of acute hospitals meaning patients stay in acute beds longer than is necessary.
- Opportunity for people with long term conditions to self-manage and receive care and support at home.

After a series of meetings, there was a change in personnel within the CCG which made it difficult to continue the work.

Key Learning Points:

- Background research carried out into the CCG priorities laid out in the Better Care Fund ensured that the offer made had a direct read across to senior personnel priorities
- Locality focussed projects can be substantially strengthened by having key housing partners involved, and the CCG did not have an established mechanism to engage, therefore welcomed this offer
- Relationships are critical – however, where possible – it is important to integrate within the systems or structures of the CCG to avoid the negative impact of changing personnel.

CCG D – This CCG was approached with a view to building on existing relationships that Sitra had formed through supporting the integration of health and social care within the locality. The core focus for this CCG was around achieving better integration of its approach to dealing with some of the most frail elderly patients

within its cohort. In order to take this forward, it was seeking support to engage housing and housing providers in strategic discussions about how to better support frail elderly, particularly those living with dementia, to live as independently as possible within the local community. The offer to support this was taken up, and initial discussions and set up meetings were established.

Despite a quite tightly defined original objective, the CCG felt that this presented an opportunity to involve senior managers from both CCG and council to engage with each other, across a broader agenda around health and housing. Whilst this was to be encouraged at one level, it became clear that the lack of specific focus meant that for a group of extremely busy people, this fell into the 'optional' rather than the 'urgent' response. Despite persistent chasing, a decision was finally taken by the CCG not to proceed due to lack of capacity.

After a series of meetings and proposals, the CCG decided that it was unable to commit to further activities during an already packed integration agenda.

Key Learning Points:

- Building on existing working relationships made for a straightforward introduction and trusted connection
- Focusing on a tightly defined outcome can be critical in releasing time and commitment from highly pressured individuals.
- Clarity around the decision making tree can be essential to ensure that your offer is pitched appropriately

CHECKLIST

Defining and making a successful offer

Have you:

1. Have you developed an offer around something they have shown significant interest in? ☒
2. Are you certain about the fit with your organisation and about your ability to deliver? ☒
3. Can you evidence the outcome in terms the CCG will accept? If not, how will you fill the evidence gap? ☒
4. Can you articulate, specifically, what it is you need them to do? ☒
5. Are you making a specific offer, or do you want health partners to co-create with you? If the latter, who are the health partners and what is the ask? ☒
6. Have you considered all the different sources of funding for your project, including from other partners i.e. not just CCG monies? ☒
7. Have you been trying to make a case for some time and not getting anywhere? Maybe it's time to step back. ☒
8. Do you have a strategy for maintaining their interest in the longer term? ☒

Section 5:

Barriers, challenges and cautionary tales

As you seek to build a relationship with your CCG or GP providers, you are very likely to come across set-backs. This is normal and you should not be discouraged but instead reflect on what you did and why it may not have worked.

Below are some common barriers and challenges that housing organisations have come across and suggestions for how to avoid and overcome them.

Lack of interest in housing: People working for CCGs, as well as GPs and Practice Managers, typically do not have a great deal of time and are not usually interested in 'housing' per se. They will not usually be very interested in hearing about the work of a housing organisation unless they can see how it relates directly to one or more of their priorities. They tend not to be impressed by glossy documents or project narrative.

Data protection: Data protection in the NHS is often a major barrier. Each CCG and GP surgery will have a nominated 'Caldicott Guardian', a member of staff with responsibility to protect patient confidentiality. Data sharing agreements have been devised elsewhere and should be sought rather than reinvent the wheel. This NHS England publication²¹ explains its Information Sharing Policy and provides some guidelines on 'information or data sharing protocols'.

Competition and privatisation: Be aware of the principles on which the NHS is founded, CCGs and GPs are often culturally sensitive to ideas of competition and privatization, and how this may affect perceptions of housing providers. Housing associations should therefore be clear about articulating their values and in particular how 'surpluses' are used at the start of partnering. ALMOs in particular need to explain their status and councils also need to articulate their strategic roles relating to private housing, enforcement and commissioning new housing as distinct from their landlord roles.

A lack of money and capacity to do strategic work within the CCG: It is common for CCGs to want to take forward a particular proposal but lack capacity or resources. Recruitment and retention, particularly in general practice, can be a problem. The 'urgent' frequently pushes out the important. They may find it particularly difficult to meet any project time constraints. If you can offer staff to lead a project, especially if they can 'speak health language', then the CCG may be more likely to agree. However, the risk with this approach is that that CCG engagement with the project dwindles if it is seen as being driven by 'housing'. If funding can be found to backfill key staff, then the CCG is also more likely to agree.

Sometimes, the CCG will pass the project over to the local authority (e.g. Public Health) to take forward but this may not be appropriate. This happened in the latter stages of working with one CCG and, after a meeting with the designated Public Health lead, the decision was made to request a senior CCG officer to be nominated to lead the project. In response to that request, two CCG officers were put forward and the project resumed with full CCG involvement.

Co-production with resident groups or tenants associations may result in volunteering. This must not be underestimated and the evidence is that residents having purpose improves health: and so volunteering is in itself a health intervention. An example would be establishing schemes to encourage neighbourliness and avoid social isolation.

Hosted by Trafford Housing Trust's THRIVE (3rd sector support) scheme and fronted by a community ambassador (a resident) and the council executive member for communities, micro grants of £500 or less were offered to un-constituted groups to improve neighbourliness. The resultant street/park parties, public art projects and community planting schemes, brought forward by never-before heard groups of residents, engaged the housebound effectively, increased community pride and brought community cohesion.

Weak relationship between housing providers operating in a locality: CCGs and providers don't have the time to hold bilateral discussions with each individual provider operating in their area. Where there is a pre-existing strong relationship between housing provider, there is scope to coordinate approaches, which can help to maximize the amount of face-time the CCG can give to housing.

²¹ <http://www.england.nhs.uk/wp-content/uploads/2014/08/info-shar.pdf>

Top tips for housing services providers: communicating with GPs and CCGs

The housing sector is alien to health professionals. It is hard to understand and is much less standardised than GP practices and primary care, making it difficult for busy GPs and CCGs to understand what housing can do in their locality and who to talk to. Housing services providers can help the process along in a number of ways. Here are some suggestions.

- **Communicate succinctly.** Assume that GPs, CCGs and other health partners are pushed for time – make sure you start the conversation with a few myth-busters or ‘big facts’ about your organisation or partnership and what it could do that make them sit up and take notice. Don’t start from the beginning, it will take too long!
- **Find the strategic lead.** Identify who is leading your GP practices and aim to talk to them. This might be the CCG, although increasingly it may be provider GPs and managers leading local networks or federations. Practice Managers are not tied to a regime of 10 minute consultations with patients and potentially have more time to engage with partners.
- **Focus on their priorities.** Put some effort into understanding what matters most to your GP practices, and develop a proposal that responds to it.
- **The NHS Five Year Forward View.** Work out how your offer to health might fit into one of the new models listed in the Forward View, and use that as the context of your conversations.
- **Do not assume GPs are well connected.** In some areas the link through the CCG to the Health and Wellbeing Board and its health and wellbeing strategy is good, but there is little connectivity in others.
- **Single conversation.** GPs find it hard to know why there are so many housing providers, what each does and who they should be talking to. Operate together with other local housing providers to put together a single locality health and wellbeing ‘offer’ from housing that is concise and coherent and that addresses the preoccupations and priorities of local health partners, can work.
- **Start small.** Aim to get one or two focused pieces of work up and running and aspire to expand your portfolio later on.
- **Solutions for morbidities.** Develop an approach to wrapping services around particular GP patients with particular illnesses (morbidity) e.g. you could offer a specific service to address cold, damp housing inhabited by children with asthma.
- **Community leadership.** If you are a major housing provider in a locality, then you can develop a community leadership role around health and wellbeing. This might involve offering up advice relating to an area of work without necessarily expecting to win every contract or it might involve leading or being part of consortia, winning and delivering contracts with others.
- **Encourage co-creation.** Persuade CCGs to move away from traditional solutions and co-create new solutions with you and your residents.
- **Be assertive and do deals.** Get on the front foot, seek out health partners that are amenable to working with you. Make specific – and evidenced offers on condition that health partners take specific actions. Make it really clear what you can do for them and what you need them to do to make it happen.
- **Show where other CCGs in partnership with housing have succeeded** – e.g. Sunderland CCG has led work on ‘Boilers on Prescription’ with Gentoo homes. Introduce the successful CCG to your target CCG and let them talk directly. Make sure you understand the rules on data-sharing – and help them to find routes to working with you that don’t contravene these.

Appendix One

Policy context: transformations in health and care

This section provides an account of the major changes that have been taking place in the NHS and in Social Care over the last five years or so, and provides some insights into future directions. It begins by describing the pivotal role played by Clinical Commissioning Groups (CCGs) and locates this within the wider health and social care system established by the Health and Social Care Act 2012. It goes on to cover in some detail the main current national drivers of change as viewed by CCGs with a particular focus on:

- National Health Service England's (NHSE) Five Year Forward View, which takes up the mantle of prevention and sets out several models for NHS partners with an area to choose and bring into being
- The Care Act 2014, which puts on a legal footing many of the emergent policy developments around personalisation, integration and housing in the context of health and care.

The Health and Social Care Act 2012 came into effect in April 2013 and introduced far reaching changes to way that the National Health Service (NHS) in England is organised. The overall aims of the reforms were aimed at:

- Putting clinicians, especially general practitioners (GPs), in charge of commissioning through the establishment of clinical commissioning groups
- Increasing patient involvement in the NHS and making services more individualised and patient-centred
- Creating a renewed focus on the importance of public health and health and wellbeing rather than just treatment of sickness
- Allowing competition in the best interest of patients

Clinical Commissioning Groups

At the heart of the structural changes introduced by the Health and Social Care Act was the establishment of CCGs which replaced Primary Care Trusts. CCGs are statutory NHS bodies responsible for commissioning and planning health care services in their local area and have been seen as the driving force for developing a clinically led NHS. There are currently 209 CCGs and key aspects of their structure, functioning, and roles are listed below.

Governance and structure

- Independent membership bodies with local GP practices as the members, operating within an agreed constitution and led by an elected Governing Body made up of GPs, other clinicians including a nurse, secondary care consultant, and two lay members
- Accountable to the Secretary of State for Health through NHSE (see below)
- Required to have a Chief Accountable Officer (CAO), who holds overall responsibility for ensuring the CCG discharges its statutory duties and functions, reporting to the CCG Board
- Beneath the CAO the particular senior management structure adopted will vary, but most CCGs will have someone with an external facing role that encompasses partnership working and/or service transformation.

Roles and functions

- Responsible for the health of populations ranging from under 100,000 to 900,000, although the average population covered by a CCG is about a quarter of a million people. Many, although not all, cover the same geographical area as the local authority
- Spend around 60% of the total NHS budget on a large range of services, including community health, routine and urgent hospital care, dentistry, mental health and learning disability services
- When carrying out their functions must have regard to reduce health inequalities and have a duty to promote innovation and integration
- Must produce an annual commissioning plan setting out what they intend to do with resources at their disposal including how they will address health inequalities. The plan must be provided to the relevant Health and Wellbeing Board (see later)
- Must also produce an annual report reporting back what they have done which must be presented at a meeting open to the public
- Are required to promote the involvement of individual patients and carers in decisions about their care and treatment and must ensure public involvement and engagement in commissioning processes and decisions. Each CCG will have mechanisms for public consultation and engagement, as will each individual GP Practice
- Can commission services from Any Qualified Provider, including from private and voluntary sector, providing they are registered with the relevant regulatory body. They also have powers to make grants or loans to voluntary organisations

- Can make use of Commissioning Support Units (CSUs) to provide services such as finance, HR, data management, contracting, and support with activities such as service transformation. CCGs can choose to buy services from CSUs or to do them in-house, whichever they feel is most efficient and appropriate. CSUs are now procured by CCGs via the NHSE Lead Provider Framework.

Whilst CCGs are an integral part of the local health and social care landscape, they are expected to act as part of a wider system and cannot therefore be seen in isolation. Other key bodies with whom they interact are described below.

National Health Service England

NHSE is responsible for managing the planning and delivery of the overall health system operating through regional and local teams. They are expected to operate at 'arms-length' from Government, upholding the NHS Constitution and in accordance with the strategic direction set by the Department of Health. Each year a Mandate is agreed with the Secretary of State for Health setting out national priorities for improving health outcomes and delivering high-quality care. NHSE has a number of functions in relation to CCGs, the main ones of which are to assure themselves that CCGs are fit for purpose and are improving health outcomes; to allocate their funding, and support their development. NHSE is also a commissioner in its own right, responsible for highly specialised services and primary care. As co-commissioners, CCGs work with NHSE local teams to ensure joined-up care. Steps are now being taken to devolve more specialised commissioning to CCGs, some of whom are now also 'co-commissioning' primary care services with NHSE. The latter includes GP services, which has entailed putting in place some checks and balances to avoid conflicts of interest.

Health and Wellbeing Boards

Each upper tier council has a Health and Wellbeing Board (HWB) to provide leadership of the local health and care system with a primary objective to improve the health and wellbeing of their population and reduce health inequalities through promoting closer integration. They are located within local government and bring together representatives from the NHS, local government and other stakeholders, including representation from the local Healthwatch. Local CCGs must be represented on the HWB. It is not a requirement that anyone from the housing sector sits on the HWB, which has been a subject of concern in housing circles.

Every HWB is required to produce a Health and Wellbeing Strategy based on a Joint Strategic Needs Assessment (JSNA) that sets out their high level priorities. CCGs have a duty to cooperate with the preparation of JSNAs. HWBs do not at present directly commission services but it is expected that the commissioning plans and actions of other local health and care organisations are consistent with the overall direction set by the HWB and this is a specific requirement placed on CCGs. In 2014 HWBs were required to sign off Better Care Fund (BCF) plans. The BCF was established in 2013 to support integration and transformation in localities. The original pot of £3.8 billion came from existing health allocations (together with the Disabled Facilities Grant funding which has been ring fenced for 2015/16). Some localities have decided to pool more so that the national size of this budget is now £5.3 billion. The focus is very much on reducing the need for hospital admissions and long term care. BCF plans have had to be endorsed by the relevant Health and Wellbeing Board and approved by NHS England.

Public Health in Local Authorities

Public health transferred to local government in April 2013 and each local authority now has a Director of Public Health and a team directed at addressing the social determinants of health, known as 'the causes of the causes' (e.g. inappropriate housing). For this year (2015/16) there is a ring fenced public health grant totalling £2.79 million which is one of the few ring fenced budgets remaining in local government. Public health departments are usually responsible for producing and updating the JSNA and can be expected to have well developed links with the CCG(s) in their area.

Healthwatch

Each area has a Healthwatch commissioned by the local authority to act as the local consumer champion for health and social care. They are guaranteed a seat on the HWB and have 'enter and view' powers to observe at firsthand how services are being delivered and gather the views of health and social care service users. They can raise alerts about specific care providers, and health or social care matters in general, and should inform local plans and priorities, as well as feeding up intelligence to Healthwatch England at the national level. CCGs should develop links with their local Healthwatch and publish the feedback they receive from them about health and care services in their locality.

Key drivers of CCG and NHS provider activity

Five Year Forward View and new models of care

In October 2014 the Five Year Forward View (5YFV) for the NHS was published. This sets out the Chief Executive of NHSE Simon Steven's vision for the future direction for the NHS. It is a key document which is likely to be a significant influence on health organisations, and especially CCGs, over the next few years, in much the same way as the Care Act is for local authorities. It is predicated on a "more engaged relationship with patients, carers and citizens" and identifies three gaps that must be addressed and which require "big change" in order to promote wellbeing and prevent ill-health. They are the:

- Health and wellbeing gap requiring "a radical upgrade in prevention and public health"
- Care and quality gap with "decisive steps to break down the barriers in how care is provided"
- Funding and efficiency gap, currently estimated to be £30 billion by 2020

Despite the lack of a specific mention of housing, the 5YFV provides significant opportunity for housing organisations. It encourages CCGs and primary care to refocus from a centralized strategy to more of a localized one, based on the culture, relationships, assets and structures that already exist and make sense to the locality. Whilst it gives a focus to both horizontal and vertical integration it refrains from dictating the detail of a single 'model', instead loosely describing several new models of care that local leaders can build on.

While it does not go as far as letting 'a thousand flowers bloom', there is a clear focus on 'meaningful flexibility' allowing different approaches to emerge in different places. This flexible, localised approach is very new to health and there remains a significant uncertainty with the idea of inventing from the bottom up. However, the flexibility also provides opportunities for housing to participate in ways that would have been unthinkable just a year or two ago.

A vanguard programme has been established with 'leading cohorts' to test out different care models. Three (of the seven) suggested models that are currently being prototyped will be of interest to housing organisations. They are:

- Multi-Speciality Community Providers (MCPs) which will be built out from groups of GP practices operating together and will include nurses, therapists and community-based professionals "to become the focal point for a range of care needed by their registered patients." They are expected to offer care in some "fundamentally different ways".
- Primary and Acute Systems (PACs) which will allow a single organisation to provide NHS list-based GP and hospital services, together with mental health and community care services. Safeguards will be put in place to ensure that these new organisations reinforce out-of-hospital care rather than simply providing a feeder for hospitals.
- Enhanced health in care homes to develop new models of 'in-reach' support to provide better tailored, active health and rehabilitation support for residents

The programme is being supported by a £200m investment fund. Both the MCP and PACs models share in common an approach based on ongoing responsibility for a defined population, rather than the provision of episodic care. The Forward Plan also sets out proposals for Integrated Personalised Commissioning (IPC). Eight IPC sites have been identified to test out approaches that will allow people with complex long term conditions bring together health and social care funding at the level of the individual. Developments such as this are closely linked to the NHS Year of Care, which aims to ensure people with a long term condition have their own personalised care plan that reflects their preferences and agreed decisions.

These new models are in addition to the existing Pioneer Programme that commenced in 2013 when 15 Integration Care Pioneers were established with the aim of making health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes. A further wave of 11 pioneers was announced in January 2015. It is expected that the learning from these sites on breaking down barriers will be shared widely and an initial report of the first year's experience of the initial pioneers has been published.

NICE guidance

One of the biggest levers for change was created when the National Institute for Health and Clinical Excellence (NICE) published their Cold Homes guidance in March 2015. In it, NICE stresses the importance of identifying those at risk of cold homes and a single point of contact for those residents to get advice and support. This is a key document which explicitly instructs CCGs and primary care providers, with accompanying evidence-based guidance on why and how, to work with the housing sector. More than this it stresses, in terms of NHS priorities such as excess winter deaths and admission avoidance, why the NHS must work with the housing sector. Housing providers would do well to 'learn' the salient statistics and evidence that the NICE guidance contains and quote it directly to commissioners – even quoting the page number and section where the evidence can be found. Since action on NICE guidance has to be demonstrated, this publication now provides a huge 'call to action' as well as the arguments for why.

There are persuasive reasons for residents to take up the offer of housing and energy improvements. Not only do housing improvements save money, the early evidence also shows great improvements in general wellbeing and happiness as well as health.

Asset-based approaches and co-production

Local authorities and housing organisations are more familiar with asset-based approaches than are health professionals, who may not be easily or fully convinced. They may need to have the approach and benefits explained in detail, with time for reflection. Certainly, the housing sector is becoming experienced in co-production with tenants and residents and holds information about their tenants that is very useful to CCGs as commissioners and GPs as providers of primary care.

Recent publications by the Health Foundation of a comprehensive review of asset based community development and Public Health England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report.pdf will provide much-needed guidance to CCGs keen to find effective ways to tackle health inequalities. Further levers for change include the Better Care Fund, the Social Value Act and the Care Act. The requirement to undertake a care and support planning process to meet the needs of clients plus a requirement to assess the needs of carers, also provide opportunities for the housing sector.

Taken together, these national drivers are making CCGs focus on:

- New Models of Care – including models to achieve community-based 'out of hospital' health care solutions
- Reducing admissions to hospital
- Addressing cold homes as a route to remedying some health conditions
- Community health hubs and multi-disciplinary teams, which housing organisations might seek to join
- Community navigator roles to connect people to community services

Local drivers of CCG and provider activity

CCGs have developed and published their own priorities in CCG Plans. They are also required to fully engage in Health and Wellbeing Strategies but the extent of wider innovation, including housing sector involvement, varies significantly. 'Joint Commissioning Priorities' that distil a common set of priorities for both the CCG and the Council to work to, are the norm. All of these local documents are important reference points to understand what the priorities are for local health partners.

NHS Outcomes Frameworks, NHS Priorities and Planning Guidance and CCG Outcomes Indicators: <http://www.england.nhs.uk/wp-content/uploads/2012/12/oi-data-table.pdf> are all key reference points and drivers of CCG local commissioning plans and provider activity.

Prime Minister's Challenge Fund – rounds 1 and 2: In October 2013, the Prime Minister announced a £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. The first wave of 20 pilots was announced in April 2014. A second wave with additional funding of £100 million was subsequently launched and a further 37 pilots agreed for 2015/16. It is worth therefore checking whether any GP Practices in your area are part of this initiative. This information is available from the NHS England web-site: <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/>

Provider-side developments and autonomy

General Practices are increasingly federating to form larger entities, operating 'at scale' and serving populations typically of between 40,000 and 60,000. These take a variety of forms and can be referred by various names including networks, federations, social enterprises, cooperatives and super practices. Operating in this way gives them more scope to address regulatory and funding challenges, to be more strategic and build relationships with other organisations, at the same time as retaining a very local and patient focus. More information on some of the changes taking place in primary care can be found in two NHS Alliance documents:

- Think Big Act Now: Creating a Community of Care: <http://www.nhsalliance.org/wp-content/uploads/2015/01/THINK-BIGACT-NOW-online-24.pdf>
- Breaking Boundaries: Reinventing Primary Care: a Housing LIN Viewpoint written for a housing audience: http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/HLIN_Viewpoint68_PrimaryCare.pdf . And also in

GPs operating at scale are more likely than small practices to have strategic leads who might have the time and inclination to connect with housing organisations. Some also have additional resources cascaded to them by CCGs to spend autonomously. Where they see direct benefits in working with housing, it may be possible to work in partnership to co-create solutions to pressing problems affecting local GPs.

Also, NHS Foundation Trusts have a great deal of autonomy and housing organisation may approach them directly with evidenced proposals for better discharge planning, admission avoidance, reducing demand in A&E for example. This Hospital to Home resource pack http://www.housinglin.org.uk/hospital2home_pack/ provides some guidance. An example of a housing organisation that has successfully engaged in this way is One Housing Group's Care Support Plus model at Tile House, Camden. This scheme provides care and support to people with complex mental health problems in conjunction with Camden & Islington. http://www.housinglin.org.uk/_library/Resources/Housing/OtherOrganisation/THExecsummaryweb.pdf NHS Foundation Trust.

Sitra

Sitra is the leading charity in the housing, health, care and support sector providing training, consultancy and advice with a membership of over 400 practitioners.

We have 30 years' experience of providing technical support to providers and commissioners. This includes policy and advice work, alongside training and consultancy on housing related support, quality, needs identification, care practice, housing management and development, together with associated activities such as personnel and staffing and financial management.

Sitra has recently incorporated the Health and Social Care Partnership (HSCP) within its wider portfolio. A key element of HSCP's work is the integration of health and social care and this furthers Sitra's wider agenda of integration of health, social care, housing and public health.

We carry out work both on a policy level and in providing specific support for individual organisations. We are a leading training provider, running both public programme and tailored in-house courses for clients around the country. We also have a large consultancy portfolio, supporting organisations to adapt and change to succeed in the emerging environment.

NHS Alliance

NHS Alliance is the leading independent voice for providers of health and social care outside hospital. It is the only not-for-profit membership organisation to bring together frontline clinicians and organisations of all kinds in our communities – from general practice, community pharmacy to providers of housing and emergency services.

It is driving a new integrated and collaborative, community-based model of care for an ageing population living with long term conditions, and is focused on breaking down the historic boundaries and silos that get in the way of truly progressive and innovative community-based patient care.

Contact us

Sitra
Can Mezzanine
32-36 Loman Street
London
SE1 0EH

020 7922 7878

post@sitra.org
www.sitra.org

 @sitrapolicy

NHS Alliance The Treehouse
2-10 Balham Station Road
Balham
London
SW12 9SG

www.nhsalliance.org

 @nhsalliance

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office as above. Company registration no. 1862908;
charity registration no. 290599

