Building Health Partnerships

Final Report

January 2013-June 2014

IVAR

Institute for Voluntary Action Research

Contents:

"Sometimes an impetus is needed to bring people together. Building Health Partnerships provides that. By focusing on just a couple of main priorities we have given ourselves the chance to see real, measurable results."

1. About Building Health Partnerships

1.1 Introduction

Building Health Partnerships (BHP) works to improve local health and wellbeing outcomes, through supporting the development of effective and productive partnerships between Clinical Commissioning Groups (CCGs), local authorities and voluntary, community and social enterprise (VCSE) organisations.

Working with 12 learning sites in phase one, BHP has led to the implementation of new approaches to re-commissioning for mental health services, opened up access to new forms of investment for VCSE infrastructure support, built momentum for change and enabled areas to pilot new non-clinical approaches to improving health and wellbeing outcomes. The approaches range from helping people to recover from ill health or injury and enhancing the quality of life for people with long term conditions through to promoting equality and inclusion.

BHP has also influenced relationships and understanding between sectors, improving awareness and use of local assets. 85% of CCGs surveyed who are involved in the programme felt that BHP would **lead to tangible improvements to health and wellbeing outcomes**, while it had helped them be **more confident in identifying and implementing cross-sector approaches** to improving health and wellbeing outcomes.[1]

"It has changed our [CCG] *understanding of the VCSE and why we need to procure services from them."* (SE Staffs & Seisdon Peninsula)

"*In the past, we always looked at Statutory OR Third Sector. Now we are looking at solving things in a more and more joined up way. This is good building for the future, modelling how we break down barriers and build trust."* (Swindon)

1.2 Programme information

Supported by NHS England, this phase of the BHP programme was delivered by Social Enterprise UK (SEUK) and the Institute for Voluntary Action Research (IVAR) in association with NAVCA, in 12 areas between April 2013 and June 2014. BHP worked directly with over 300 senior staff from CCGs, local authorities and VCSE organisations (see Section 4 for more details)

The aims of this phase of the programme were to:

- Assist meaningful engagement between CCGs and the HWB Partnership and residents/ patients, carers and their communities
- Build trust and mutual understanding between VCSE organisations, CCGs and HWBB/Local Authority
- Enable senior staff in CCGs, VCSE and HWBB to take key leadership roles in responding to challenges of transforming health commissioning and delivery
- Support a local programme of intervention for more effective engagement of the VCSE sector
- Share models of and experience of effective approaches to cross sector commissioning.

Each learning site received a bespoke programme of facilitated support, with 15 to 25 senior leaders from the CCG, local authority and VCSE in each area taking part.

[1] IVAR and SEUK (Sept 2013) *Building Health Partnerships: National Learning Development*.

The core sessions included the following:

- A diagnostic session to create a shared understanding of the national and local health policy context
- A partnership development session to cement partnership working and develop an area-based action plan to address the key challenges
- An expert seminar to tackle specific local needs and build local knowledge
- A partnership development session to embed learning and review delivery of action plans
- Additional bespoke support and facilitation from a dedicated facilitator.

In addition each learning site was able to access a bursary of up to £50,000 (managed and administered by NAVCA ad reported on separately by them to DH) to fund specific project work that supported the objectives of the programme.

A series of national sessions also supported the delivery of the programme, offering opportunities for the twelve learning sites to come together with other areas and share their experience and developing expertise. These sessions included:

- A national learning workshop in London on 18th June 2013
- A social prescribing action learning set held in Swindon 14th March 2014
- A demonstration site visit, hosted by the Manchester learning site on 4th April.

2. Key achievements of Building Health Partnerships

2.1 Introduction

Through BHP the 12 learning sites piloted a number of new joint approaches, including:

- Addressing health inequalities for LGB&T individuals
- Measuring social value and its impact on health outcomes for individuals
- Improving community resilience and reducing reliance on primary care services
- Developing the use of social prescribing, contributing further to the knowledge base around this approach.

(See section 5 for more details of the 12 learning site projects.)

The BHP programme has demonstrated that it delivers against key objectives for NHS England:

- Demonstrating that integrated services, culture change and preventative community healthcare are achievable with proper investment in partnership improvement.

- Forming productive cross-sector partnerships which deliver tangible improvements to health outcomes.

- Raising awareness and understanding between sectors, leading to greater confidence in acting in partnership.

- Placing communities at the heart of defining their healthcare needs, and giving them the skills and support to influence and shape the delivery of their local healthcare.

- Building a strong evidence base around key emerging themes such as social prescribing and social value, which can be used to influence and inform future work.

2.2 Practice Development Network

The programme also established a **Practice Development Network** to share and disseminate the learning from the programme, locally and nationally.

Significant achievements have included:

- 30 senior health practitioners from across the twelve learning sites have agreed to act as ambassadors for the programme and to lead on learning and sharing with other CCGs
- Four of the learning sites represented BHP at the Health and Care Innovation Expo in March 2014
- BHP ambassadors have presented at the Northern Ireland Assembly, sharing good practice from the programme with health and care professionals and the VCSE sector in Northern Ireland
- Case studies on eleven of the twelve areas have been produced.

2.3 Feedback from Clinical Commissioning Groups[2]

In September 2013 IVAR and SEUK interviewed 15 representatives (senior staff or board members) of 8 CCGs involved in the programme; we also administered an anonymised online survey which was completed by 17 representatives (senior staff or board members) of CCGs involved in the programme (a response rate of 55%: the survey was sent to 30 people). The findings demonstrated that the programme was delivering on the key aims of BHP (see Appendix Two).

More than 75% of survey respondents said that BHP has contributed to the **CCG being able to identify practical solutions to improving health and well-being outcomes and has helped the CCG feel more confident about cross-sector approaches** to improving those outcomes: *The biggest benefit that BHP has brought has been the facilitation of working and networking across organisational boundaries.*

More than 80% of survey respondents said that **BHP has helped the CCG to be meaningfully engaged with VCSE organisations**: *What is standing out for me at the moment is around trust and understanding.*

Getting a conversation going where there was no conversation previously; lots of practical outcomes and products a bit further down the line better understanding of the VCSE offer by health and care commissioners.

2.4 The longer term impact of BHP

It is now possible to appreciate the longer term impact that the BHP programme will have for some of the learning sites. Below are some examples of the changes that BHP has resulted in which will have a lasting impact on how CCGs, local authorities and VCSE organisations work together to improve local health outcomes.

Swindon BHP partners have formed an ongoing VCSE-led forum where the CCG, LA and VCSE will continue to meet bi-monthly to discuss potential for integration and collaboration as new opportunities arise and to make links between different person-centred initiatives in the borough. The Wellbeing Coordinator project will be rolled out from the current cohort of 22 individuals in the transition from secondary to primary mental health care to other services in Swindon.

North Hampshire CCG and the three local CVS, in collaboration with Hampshire and IoW Community Foundation are setting up a fund (drawing in corporate as well as statutory funding and to be administered by the Community Foundation) to enable the CCG to commission small community organisations to deliver community-based activities to meet some of the non-clinical needs of patients.

Dudley CCG has invested £400,000 in the PSIAMS social impact tool, designed by a VCSE organisation and shared through BHP to be rolled out for use with all commissioned services in the borough.

Manchester BHP partners have created a dataset of LGB&T health needs as a tool for commissioners and other VCSE organisations designing services, as well as a LGB&T implementation framework and a best practice model for organisations working with other under-represented groups.

[2] IVAR and SEUK (Sept 2013) *Building Health Partnerships: CCG report*

Staffordshire BHP partners are testing a new commissioning model for the frail elderly and people with long-term conditions round social isolation, the results of which will be used to inform the upcoming pulmonary rehab specification and make a huge difference to CCG grant-making in the future.

Hackney BHP partners are now carrying out a robust evaluation of the Social Prescribing model; the scheme itself is funded for the next two years by the CCG and aims to ensure future referrals and mapping of new services, in a multi-team effort.

In **Durham**, the new Community Health Navigators have dealt with increasing numbers of referrals as GPs adopt this community-based approach and the CCG and VCSE are developing an experience-led commissioning team to embed patient and partnership engagement in the commissioning process.

3. Learning from Building Health Partnerships 2013-2014

The delivery of the programme has confirmed a number of factors for the success of the programme.

- Timing: The importance of seeing change as a process, rather than an event, allowing relationships to be built and ideas to be turned into action.

- The need for genuine cross sector senior buy in and diverse involvement to drive forward change.

- A high level of support: Bespoke facilitation, access to experts and resources to support learning sites to work in partnership to pilot new ways of working.

- A dual focus: On relationship building as well as joint action. And the importance of not rushing people to action. BHP participants have been grappling with complex, emerging structures, new relationships and unfamiliar opportunities: for new, joint initiatives to have a chance of being useful and effective, the foundations (relationships, common ground, mutual understanding) will need to be in place.

- The role of a bursary: The additional money enabled learning sites to pilot projects they would not otherwise have been able to fund, it acted as a catalyst and ensured that key senior staff were willing to engage with and take the programme seriously.

As the programme has developed, we have also noted the importance of thinking about sharing and learning, both locally (as part of the programme legacy) as well as nationally (for other interested parties). For example with a number of the learning sites piloting different approaches to social prescribing and social value there is a wealth of data being generated to inform best practice.

Many of the learning sites are keen to continue to engage as a network, and are interested in applying for joint funding and sharing data to enable in-depth impact measurement of approaches and the development of good practice around approaches such as social prescribing and social value. The Practice Development Network has gone some way to developing a structure through which this can be achieved, yet there is scope to improve the links between existing NHS England networks, such as the lay CCG members network.

4. The twelve learning sites' projects

Learning Site	Priorities	Outcomes
Bristol Falls prevention training programme aimed at GPs and others working with people at risk of falling, to support them to recognise those at risk, and signpost or prescribe community-based activity to support independent living.	Introduction of social marketing/prescribing and implement GP education initiative around falls. Develop strong relationship between health commissioners and VCSE for a more collaborative approach to health and care. Strengthen the bridge between statutory and the VCSE for diabetes prevention – commission a piece of work to engage BME communities in service development around diabetes.	Built momentum around the focus on social value with a view to developing the commissioning framework. Recommissioning of mental health services undertaken in a new way, really supporting VCSE engagement from the outset: "*finally someone's listened and understood what we need to get involved in commissioning*". Closer [cross- sector] relationships. Better engagement of BME community in service development around diabetes. Reduced falls and increased independence of vulnerable older people. CCG commissioners and Public Health commitment to involving VCSE in re/commissioning.

Learning site	Priorities	Outcomes
Dudley Developed a **common system for providers to demonstrate and measure their social impact, social value and social capital,** and use the data and information in a new conversation and relationship with commissioners of health and social care.	Action to join up the VCSE offer resulting in a better information base to agree health priorities and access services, and demonstrate the VCSE contribution to the patient experience. Develop collective and inclusive engagement structures in order to influence commissioning and support co-production by engaging the VCSE at all stages of the commissioning cycle. Create a partnership of VCSE organisations who use a common system to demonstrate and measure their social impact, social value and social capital, and use the data and information in a new conversation and relationship with commissioners of health and social care in Dudley borough. New evidence collection system piloted (led by VCSE organisation).	As a result of BHP the CCG has commissioned a common system (PSIAMS) developed by a local social enterprise, for all providers to use to demonstrate and measure their social impact, social value and social capital, and use the data and information in a new conversation and relationship with commissioners of health and social care. The CCG can engage VCSE organisations to influence commissioning and promote co- production in all stages of the commissioning cycle, using improved data and evidence which they collect.
Durham A Community Navigators scheme which supports individuals and GPs to take up local VCSE interventions and activities, and lessen the need for clinical solutions.	New approaches to the prevention of health problems (including stroke prevention) through Community health champions and ensure these new approaches work across different health conditions and groups**.**	"*The action plan will enable differences in practice and approaches between public health staff and the VCSE to be minimised*". Cultural change in GP practices. Closer working within the VCSE. Out of this work Durham CCG and VCSE are developing an experience-led commissioning team, embedding patient and partnership engagement in the commissioning process. Cohesive approach and practice between public health staff and the VCSE. Potential for technological advances in the future.

Learning site	Priorities	Outcomes
Hackney Social prescribing pilot, prescribing alternatives to traditional medication and treatment options.	Piloting a social prescribing model with focus on over 50's isolated; Turkish/Kurdish community; those with type 2 diabetes.	Cross-sector familiarity with and support for the social prescribing model. Better cross-sector knowledge about the full breadth of the VCSE. Gaps in services will be recorded by the Social Prescribers and regular feedback provided to the GPs. An interim evaluation of the programme will be available in July 2014. The CCG are hoping to fund an extension of the pilot.
Manchester A Greater Manchester Dataset on LGB health needs, accompanied by a replicable model, good practice guidance to provide practical support to VCSE organisations on ways to develop a robust and recognisable evidence case to inform commissioning decisions for other under-represented groups.	To capture and explore LGB & T people's experience of health and care. Make the economic case; research unmet needs; comparisons elsewhere; cross-boundary commissioning approach (GM); economic savings, clinical rationale; design a 'best practice' framework.	Economic case built on evidence of need for investment in equitable health services for the LGBT population. Greater Manchester dataset and comparative models produced to influence commissioning decisions in the future. Sexual Orientation Monitoring: introduced and extended to all South Manchester GP practices. Clinical rationale: a clear and well written argument for future investment. Pride in Practice: embed across all South Manchester GP practices; extended the information to include guidance on health needs in the Trans community. Replicable model: A clear pathway of practical and realistic actions within a best practice guide that could be applied to and inform other under- represented groups Learning and resources available here: http://www.lgf.org.uk/policy-research/building-health-partnerships/

Learning Site	Priorities at first session	Outcomes
North Hampshire Social prescribing pilot built around a volunteer surgery based Wellbeing Guides scheme; Research and co-design of additional pulmonary rehab services for patients with COPD, potentially funded through a social impact bond.	Improved mental health and wellbeing of people with long term conditions (LTCs) through better self-management of LTCs and more opportunities for VCSE in the design and delivery (commissioning) of interventions. Surgery-based Social Prescribing for specific health areas: focusing on improved mental health of people managing long term conditions starting with COPD, diabetes and stroke. Research leading to a new commissioning model for increased uptake of pulmonary rehabilitation.	Widespread interest in the innovation of 'social prescribing' volunteers. Improved understanding of the local VCSE support available to patients with COPD. New models of partnership working to influence the future direction of the HWWB; new opportunities for cross-sector collaboration, as well as partnership working within the VCSE sector. Greater awareness, promotion and uptake of community based health and wellbeing initiatives, including those supporting resilience and wellness in relation to mental health and the wider determinants of health. Improved care and support for people with COPD. Developing relationships with local funding bodies and companies to create fund to support community infrastructure.
SE Staffs & Seisdon Peninsula Initiative to collect evidence on need for the Frail Elderly and people with Long Term Conditions, and then pilot VCS service responses, with impact measured by an external body, to lead to new commissioning model, and new service approach.	Identify needs of customer/client group and support via own interventions or via brokerage. Research the impact of VCSE support; use results to inform a prime contractor model pilot via Compact Contract Management (CCM) - a special purpose vehicle established to bid for and manage contracts on behalf of smaller VCS orgs/consortia etc. in SESSP.	The process for commissioning the voluntary sector: *"the CCG is able to make links and lead the process more effectively".* *"It has changed our [CCG] understanding of the VCSE and why we need to procure services from them".* Piloted VCS service responses to the identified need and impact measured by external body. Pilot a prime contractor model for commissioning services from VCSE - based on need. Economic case for potential replication in other health domains Influence local commissioning practice (e.g. a revisited grants system). Increased awareness of VCSE through engagement with CCG (marketplace events planned).

Learning site	Priorities at first session	Outcomes
Shropshire The creation of a digital 'Map of Maps' as a source of information on the VCSE offer to commissioners, the public and patients of Shropshire, highlighting the value of the VCSE and making a case for future commissioning priorities.	Move to cooperative commissioning; promoting the sustainability of the local health and social care economy, and enabling individuals and communities to be more self-sufficient. Promote better access to preventative and non- traditional health and wellbeing support and solutions enabling the identification of gaps in provision/need for new support. Measures and criteria to address inequalities, communication and quality standards will be built into all local Shropshire activity.	Digital Map of Maps to improve engagement between CCGs and VCSE and support commissioning process. A compulsory training package including a conference event for all commissioners about the breadth of services of VCSE organisations (including their social capital) and ways commissioning processes can support them to be effective (building on the compact agreement). Extending the GP Community and Care Coordinator scheme. Raised awareness between the CCG and VCSE of each other's work and priorities. Embedding the principles around partnership working and its importance.
Swindon Social Impact Bond to fund Social prescribing pilot for people being discharged from secondary mental health services.	Effective plans around individual needs through volunteer 'champions' Identifying, engaging and supporting stakeholders Social Impact Bond to develop the provider market, increase resilience and reduce hospital costs.	"*We are more linked up with government initiatives and policy direction*". "*The VCSE is coming together to be a voice and to be part of something designed for the future with the CCG and the council – this programme is a vehicle for that*". "*Now we are looking at solving things in a more and more joined up way. This is good building for the future, modelling how we break down barriers and build trust*". VCSE coming together as part of as a strong and flexible forum designed for the future with the CCG and borough council. Commissioned Social Finance to produce an options appraisal for Social Impact Bond. Potential substantial investment for VCSE health and care providers through Social Impact Bond Increased community resilience and reduced hospital costs. Joint training for commissioners and community-based workers on effective and appropriate consultation and engagement.

Learning Site	Priorities at first session	Outcomes
Wakefield The establishment of social prescribing pilot programme, alongside the development of a replicable mechanism for assessing and articulating impact in terms of monetary and social value.	Establish a new model for commissioning, structured around engagement, innovation and participation of the VCSE in partnership with other providers, with individual and communities' wellbeing at the centre. Development of social prescribing pilot; implementing social value in health commissioning; evaluating impact of above on outcomes.	"*I understand more about the CCG – its culture, imperatives, constraints*". Straight, direct communication. "*By focusing on the practical, we've identified something which will benefit us all*". A chance to make time to think, in a very constructive way, "*which is really precious*". Evidence impact and social value of social prescribing project. Social value implemented in health commissioning across Wakefield.
Bradford The establishment of Health and Wellbeing Hubs which will ensure greater engagement between the CCG and the VCSE; 'care navigators' to act as sign-posters and information-providers, thereby reducing clinical interventions.	Develop and implement local programmes of intervention for more effective engagement of the VCSE sector in health commissioning and delivery of improved health outcomes.	Research commissioned to investigate and assess care navigation systems locally, and alternative models adopted elsewhere. The findings and recommendations will assist CCG commissioners in identifying best practice in care navigation, and inform their commissioning decisions in this area. It ultimately has the potential to lead to better local care navigation for patients.

Learning Site	Priorities at first session	Outcomes
Croydon The identification of 'community connectors' who will bring together local people and groups to focus upon health and wellbeing issues which they themselves have identified, leading to more effective use of local GP surgeries and a greater emphasis upon local initiatives.	Improve health and wellbeing outcomes through asset based community. Understand the barriers to the approach and examine the social causes of health problems; map existing services and activities; identify key connectors, the people who can make things happen; and identify issues that will enable people to enact their own solutions.	A greater number of local residents are relying less on primary care, with front line staff in health care settings able to sign post to 'asset based community development' projects, engaging over 300 users to date. The new projects include a healthy eating breakfast club, a relaxation group for parents and a community newsletter informing residents of health initiatives. These projects are helping drive people away from costly services and care centres and into supportive social networks.

Appendix One: Building Health Partnerships Reports

Building Health Partnerships progress report, May 2013

Building Health Partnerships delivery progress report, July 2013

Building Health Partnerships Emerging Actions, Aug 2013

Building Health Partnerships, CCG report, September 2013

Building Health Partnerships Learning Site progress report, November 2013

Practice Development Network update, February 2014

Five Social Prescribing Pilots, Building Health Partnerships, February 2014

Social Prescribing Action Learning Set, Report, March 2014

Five Case Studies, Building Health Partnerships, March 2014

Practice Development Network update, March 2014

Appendix Two: Building Health Partnerships: National Learning Development
Summary

1. Building Health Partnerships (BHP) is a national programme funded by NHS England and delivered by a partnership of NAVCA (National Association for Voluntary and Community Action), Social Enterprise UK and IVAR (the Institute for Voluntary Action Research).

2. To help develop thinking about how best to share the learning from the current phase of BHP, IVAR and SEUK interviewed 15 representatives (senior staff or board members) of 8 CCGs; we also administered an anonymised online survey which was completed by 17 representatives (senior staff or board members) of CCGs involved in the programme (a response rate of 55%: the survey was sent to 30 people).

3. The feedback about the importance and significance of BHP for CCGs was overwhelmingly positive:

    - More than 75% of survey respondents said that BHP has contributed to the CCG being able to identify practical solutions to improving health and well-being outcomes and has helped the CCG feel more confident about cross-sector approaches to improving those outcomes: *The biggest benefit that BHP has brought has been the facilitation of working and networking across organisational boundaries.*
    - More than 80% of survey respondents said that BHP has helped the CCG to be meaningfully engaged with VCSE organisations: *What is standing out for me at the moment is around trust and understanding.*
    - More than 85% of survey respondents said that the programme will lead to tangible improvements to health and well-being outcomes: *Getting a conversation going where there was no conversation previously; lots of practical outcomes and products a bit further down the line*
    - Interviewees emphasised the critical contribution of BHP to building effective and constructive cross-sector working relationships, based on mutual understanding and a shared commitment to improvement and change: *We are together because through BHP we now have a common understanding of health needs.*
    - The importance of a structured programme of support was also stressed: *Sometimes an impetus is needed to bring people together, BHP did provide that. By focusing on just a couple of main priorities we have given ourselves the chance to see real measurable results.*

4. The need for this work to continue was highlighted:

    Really important for NHS England to keep working on this because there's a risk important work developing relationships within your community will get lost because of all the other pressures. CCGs working with their community are a really key issue.

    BHP has been a bridging – its strength is the ability of something like this to create an interest and impetus, but also create something that spans gaps between organisations. If I were in NHS England now, that's what I would be interested in, in terms of benefits.

5. CCGs involved in BHP are enthusiastic about the principle of sharing learning from the programme at all levels – with each other, locally, regionally and nationally. Action learning opportunities, supported by web-based resources, are favoured. However, concern is widespread about the resource implications, as well as the potential for the CSU or LAT to take

this work forward: *I don't see the CSUs have got this on their radar at all; This sort of initiative is much better managed locally and delivered at grassroots level*; *By hook or crook, NHS England and LATs will only see part of the overall picture.*

1. Background

1.1 Building Health Partnerships (BHP) is a national programme funded by NHS England and delivered by a partnership of NAVCA (National Association for Voluntary and Community Action), Social Enterprise UK and IVAR (the Institute for Voluntary Action Research). Its aim is to improve health and wellbeing outcomes by:

- Assisting meaningful engagement between CCGs and the HWB Partnership and residents/ patients, carers and their communities
- Building trust and mutual understanding between VCSE organisations, CCGs and HWBB/Local Authority
- Enabling senior staff in CCGs, VCSE and HWBB to take key leadership roles in responding to challenges of transforming health commissioning and delivery
- Supporting a local programme of intervention for more effective engagement of the VCSE sector
- Sharing models of and experience of effective approaches to cross sector commissioning.

1.2 The national context for BHP is the ongoing reform and modernisation of the health service, and the emerging consensus that individuals and the communities that they live in need to be at the heart of defining need and designing responses, as part of a wider move away from acute/emergency services and into prevention and more integrated, community-based provision.

1.3 An integrated programme of support, advice and expert guidance is currently being delivered in 12 areas across England. Learning from the work carried out to date suggests that support interventions for achieving change locally need to recognise the essential contribution that VCSE organisations can make to improving health outcomes, and build on the energy and desire to work together across organisational and sectoral boundaries in order to realise the value that individuals and communities can bring to their own care.

1.4 Most of the twelve local areas participating in the current phase of BHP are already making significant progress towards achieving tangible and meaningful improvements. In addition, we can begin to identify some of the conditions required for local change, as well as the critical points along the patient pathway where cross-sector working can be most effective, including: the flow of information between individuals and agencies; non-medical options for health and care; asset-based approaches to design and delivery; and a greater emphasis on prevention.

1.5 The delivery of the programme has been informed by four critical success factors highlighted by the earlier BHP pilot[3]:

- Timing: The importance of seeing change as a process, rather than an event, allowing relationships to be built and ideas to be turned into action
- Cross sector senior buy in and diverse involvement
- A high level of support: Bespoke facilitation, access to experts and resources

[3] http://www.socialenterprise.org.uk/uploads/files/2013/06/powerpartnershiptoolkit_onlinefeb13.pdf

- A dual focus: On relationship building as well as joint action. And the importance of not rushing people to action. BHP participants are grappling with complex, emerging structures, new relationships and unfamiliar opportunities: for new, joint initiatives to have a chance of being useful and effective, the foundations (relationships, common ground, mutual understanding) will need to be in place.

1.6 As the programme has developed, we have also noted the importance of thinking about sharing and learning, both locally (as part of the programme legacy) as well as nationally (for other interested parties). A key part of this is the need to provide support for other areas to adapt, adopt and implement new approaches to improving health and wellbeing through partnerships between CCGs, VCSE organisations and local authorities.

2. Introduction

2.1 In order to develop our understanding of the possible options for developing and organising learning, we carried out a consultation exercise with key CCG staff and board members involved in the BHP during August and September 2013. We were particularly interested in assessing people's experience of the current programme, as well as their views and ideas about what structures and networks could be used for sharing and learning.

2.2 Our consultation comprised:

- Semi-structured interviews with 15 representatives (senior staff or board members) of 8 CCGs
- An anonymised survey completed by 17 representatives (senior staff or board members) of CCGs involved in the programme (a response rate of 55%: the survey was sent to 30 people)

2.3 In addition we spoke to senior staff from local authorities and VCSE organisations in five of the BHP areas; we also reviewed documentation from all 12 areas.

2.4 A list of interviewees is set out in Appendix One. In Appendix Two, we present a summary of the survey results. Finally, in Appendix Three, we summarise the anticipated outcomes from the 12 BHP areas.

3. CCG consultation findings

Introduction

The data from our consultation were analysed thematically using a system of open coding of interview transcripts and other material. We set out a brief summary of our findings under four main headings. We refer throughout to representatives of CCGs as 'participants'; unattributed comments (from both the interviews and the survey) are presented in italics. We conclude with some tentative thoughts about how this work might be taken forward – these will form the starting point for the discussions at the Participation and Partnerships Working Group of the CCG Assembly on 24th September in Birmingham.

3.1 Laying the foundations for change

3.1.1 Relationships and mutual understanding

Most participants highlighted the importance of developing cross-sector working relationships based

on mutual understanding and trust, as well as the joint identification of *shared* priorities:

So far the net benefit has been the opportunity to raise awareness in the CCG and its committees, its clinical networks and practices, of the VCSE, and vice versa. Getting a conversation going where there was no conversation previously.

It's all about building the relationships. We have learnt that leadership is all about facilitation, not about dictating or contract management. You need a collaborative, value based, outcome based approach. It is a complete anathema to much of the guidance coming out around contract management and commissioning.

We are together because through BHP we now have a common understanding of health needs. We have been able to pilot things we've never been able to make happen before.

The biggest benefit that BHP has brought to has been the facilitation of working and networking across organisational boundaries.

3.1.2 **High level commitment and focus**

Linked to the importance of relationship building is the involvement of senior staff - What *has been unique is the high level leadership involved: it's pushed it higher up the agenda* - and the concentration of effort and attention on getting things done together:

There have been many benefits but for me one of the most important has been the fact that, by participating in the programme, we have focused minds.

There's something about being part of a national programme that attracts people into it more. It helped us accelerate our thinking and helped us get on with the work.

Sometimes an impetus is needed to bring people together, BHP did provide that. By focusing on just a couple of main priorities we have given ourselves the chance to see real measurable results.

3.2 Key learning

3.2.1 **Appreciation of the VCSE offer**

For CCGs, BHP has provided the opportunity to get to grips with the potential role and contribution of VCSE organisations to improving health and wellbeing:

Really useful to have such a better understanding of a particular client group – builds information and knowledge.

A lot of care is being carried out by voluntary organisations – we just need to link up with them in a better way.

[We now] *recognise the value of the VCSE and that they're an important set of partners that we need to develop with and continue working with.*

More specifically, BHP has helped CCGs to focus attention on specific areas of development:

[The VCSE offer] *fits very well with our agenda, especially where we are integrating services at a local level. The information on the offer from BHP will now be a key component of this exercise, especially around community assets and resilience.*

There is also some early learning coming out about social value, and different ways of understanding different contributions to the overall health and social care economy.

One of the benefits from BHP has been to unlock the development of the local Mental Health Wellbeing Coordinator scheme. This scheme will provide those with mental health challenges but who do not have mental illness (and thus are not engaged with secondary care services) to access support and be navigated to third sector, voluntary and neighbourhood resources. It prevents the hard to handle periods of stress from becoming enduring mental illness or life time medicated. It works with employers to keep people in work rather than invest millions to get them back to work later. Without the BHP programme to help us focus the scheme and find important investment to allow the promoters of the scheme to better define its benefits, this would not have proceeded.

3.3 Tangible changes

In addition to the planned outcomes in their areas (see Appendix Three), CCGs identified two specific areas of tangible change arising out of their involvement in BHP.

3.3.1 Commissioning and delivery of health care

Building on the relationships and insights generated through BHP, CCGs plan to make significant changes to commissioning:

When we look to commission a new service – [we will now] *see if there is a voluntary group already doing some or all of the work, then link up or add our element to the work already being done.*

In my role I support the prioritisation process and it's brought home to me how we overlook the VCS as suppliers and we don't really understand how the sector works. We have very big systems and they are not always applicable to smaller groups – we will make changes to these processes.

[We will be] *improving the intelligence of the commissioning process and making sure the VCSE is plugged in at each stage.*

3.3.2 Engagement and relationships

Alongside these changes to formal commissioning processes, CCGs also plan to work more effectively with their new network of VCSE contacts:

There are better opportunities for the VCS contribution to be incorporated as a result of BHP.
For me personally I have an opening of a network, a ring of individuals and organisations that they represent that I can now interface with.

I now know that if I have a question, I ask it differently, to different people than I would have before.

3.4 Sharing the learning

3.4.1 Cluster approach

In thinking about options and opportunities for sharing the learning from BHP, most participants

favoured beginning with a local/regional focus:

Sharing the learning across our CCG first: get it right here first.

I would start with cluster or neighbouring CCGs and facilitate a sort of sharing session [with] the pilot CCGs.

3.4.2 **Networks**

Building on local dissemination, there was a lot of enthusiasm for developing learning networks:

Growing networks is best: existing participants need to reflect on their own learning; [then] *consider where else to expand/extend to, e.g. an action learning set.*

We [could] *develop a hub and spoke model for our area.*

3.4.3 **Action learning**

For many CCGs, the action learning approach – revolving around the experience of the 12 BHP areas was preferred:

NHS England should use these first 12 areas to be demonstration sites. We as learning centres need to run conferences, learning events, write them up, invite others to learn about how we made things work here in the patch. Become hubs of wider networks. Create a learning exchange. Set up master-classes etc to do dissemination.

Great if they repeated process with a new group and then had another learning event where the first cohort could share where we'd got to and the new cohort could share what they were working on. [Then] *have an annual event, with each new wave, to keep it on agenda. Be a travesty if NHS England treated it as a one off and that's it.*

If NHS England decides they will do a round 2 or 3 of BHP, it would work best if the new areas can use and develop some of the things that have come out of this programme. There are some things that have come out here, perhaps we can take those into new CCGs, to explore, refine, test out, hone in on certain things that are logical next steps of things that have been tried locally through this programme.

3.4.4 **Online and social media**

As part of this interactive approach to learning, the importance of online and social media was highlighted:

What I would prefer is some kind of write up and sharing of good practice: 'in our area we did this, these are the products, these are the outcomes, this is where we are going in the future'. I'm always interested to know what other CCGs are doing and thinking BUT what works in one CCG won't work in another. The easiest thing would be some kind of a website.

3.4.5 **Organisation of the learning: concerns about LAT and CSU**

In thinking about appropriate mechanisms for the organisation of learning for CCGs (and their partners), a number of participants raised concerns about existing structures:

This sort of initiative is much better managed locally and delivered at grassroots level. The current model has worked really well. Support from the CSU and LAT is murky and differs by CCG.

It works as it is, [it's the] *best format for working together on the ground – it's all about local solutions and relationships. We get no support from LATs and the CSU has particular functions only. I don't see the CSUs have got this on their radar at all,* [they are] *very focused on business contract management and reporting. My concern is CSUs are so focused on acute services they haven't got to community services yet; I don't think they'd be able to cope with the VCSE.*

By hook or crook, NHS England and LATs will only see part of the overall picture. One of the things the BHP has enabled us to do is delve into other areas and open up other opportunities that we would not have known about. It has been the workshops that have been the critical success.

3.4.6 **Involvement in the learning**

However, despite almost universal interest in being actively involved in sharing and promoting the learning from BHP, most participants expressed caution about the resource implications:

In principle absolutely yes, with the obvious caveat of constraints of time and capacity.

My heart would love to be involved but my head says I would not have time. And I am not sure you can create time.

3.5 Next Steps

The responses to our questions about sharing the learning from BHP raise three key questions about future work in this area.

3.5.1 Experiences of cross-sector working to achieve improvements to health and wellbeing outcomes vary from area to area – shaped by a number of factors including history, culture, relationships and resources. This points to arrangements for sharing and learning that are dynamic and flexible, balancing core elements with more bespoke features. Can this approach be accommodated within NHS England's existing plans?

3.5.2 More specifically, the process of sharing and learning needs to begin locally (within and between CCGs, relevant VCSE organisations and local authorities), in order to embed new and different ways of working. Beyond that, there is clearly an appetite to share learning both geographically and thematically. In order to preserve the distinctive cross-sectoral, collaborative essence of BHP, how might the bridging and linking work (across areas and themes) be organised and resourced?

3.5.3 Our consultation with CCGs confirms the importance of relationships to effective and productive cross-sector working. The dual focus of BHP on relationship building as well as joint action has been critical. This suggests that some kind of action learning approach – organised both geographically and thematically, and supported by learning materials drawn from local initiatives – could work best. How might this be organised, coordinated and resourced?

Appendix One: List of interviewees for BHP CCG consultation

Name	Role	Organisation
Steve Davies	South Bristol Representative	Bristol Clinical Commissioning Group
Tony Jones	Patient and Public Involvement Lead	Bristol Clinical Commissioning Group
Sandra Carter	Social prescribing project officer	NHS City and Hackney Clinical Commissioning Group
Helen Ashford	Community Engagement Advisor	NHS Dudley
Neill Bucktin	Head of Partnership Commissioning	Dudley Clinical Commissioning Group
Paul Maubach	Chief Officer	Dudley Clinical Commissioning Group
Dr David Hegarty	Chair	Dudley Clinical Commissioning Group
Jayne Cooney	Practice Manager, Business Contract and Performance Lead	South Manchester Clinical Commissioning Group
Val Bayliss-Brideaux	Communication and Engagement Manager	Greater Manchester CSU
Richard Caulfield	Lay Member, Patient and Public Involvement	South Manchester Clinical Commissioning Group
Anne Philips	Communications and Patient. Participation Manager	North Hampshire CCG
Bharti Patel-Smith	Director of Governance and Involvement	Shropshire CCG
Karen Higgins	Support for patient involvement	Shropshire CCG
Tony Ranzetta	Accountable Officer	Swindon CCG
Lee Beresford	Associate Director of Strategy and System Development	NHS Wakefield CCG

Appendix Two: Summary of BHP CCG survey responses

To what extent would you agree/ disagree with the following statements about participation in the Building Health Partnerships (BHP) programme?						
Answer Options	**Agree**	**% Agree**	**Disagree**	**%Disagree**	**N/A**	**Response Count**
BHP has helped the CCG to be meaningfully engaged with VCSE organisations	15	88	1	6	1	17
BHP has helped VCSE organisations to be effectively engaged in health commissioning and delivery	12	71	3	18	2	17
BHP has helped to build trust and mutual understanding between the CCG, local authority and VCSE organisations	12	71	4	24	1	17
BHP has helped senior CCG staff to show leadership in transforming health commissioning and delivery	8	47	8	47	1	17
BHP has contributed to the CCG being able to identify practical solutions to improving health and well-being outcomes	13	76	3	18	1	17
BHP has helped the CCG feel more confident about cross-sector approaches to improving health and well-being outcomes	13	76	3	18	1	17
BHP will lead to tangible improvements to health and well-being outcomes	14	82	0	0	3	17
BHP will lead to sustainable improvements to health and well-being outcomes	12	71	2	12	3	17
					answered question	**17**