HEALTH AT THE HEART OF EVERY DECISION

CAMBRIDGESHIRE AND PETERBOROUGH INDEPENDENT COMMISSION FOR PUBLIC SERVICE REFORM

November 2020

CONTENTS

Foreword

FROM THE CHAIR OF THE COMMISSION

The Cambridgeshire and Peterborough Independent Commission on Public Service Reform (CPICPSR) is pleased to publish our full report. This follows on from the Interim Report that was completed in October 2019.

The Commission was established and funded by the Cambridgeshire and Peterborough Combined Authority and has focussed on health and social care. We have considered how the Combined Authority and all its partners and stakeholders might best contribute to improving health and wellbeing across the entire population that it exists to serve. We have however, also thought beyond the specifics of our region towards solutions that could be adopted elsewhere.

On behalf of the Commission I would like to thank those who gave up valuable time to be interviewed as part of the research process. They have helped us form the understanding required to develop principles and recommendations. If these conclusions are acted on, the prize will be improved health outcomes whilst simultaneously building resilience, responsiveness and better value over the medium term.

In our interim report in August 2019 we said that to achieve improvements in people's health and wellbeing, there is a need to strengthen the shared sense of responsibility, accountability and willingness to work together. We found support for this. Most of the people we talked to wanted to develop ways of working that would deliver stronger, more localised prevention and care. This means change that will cross established boundaries and barriers, whether they be organisational, physical or budgetary.

The Covid experience has graphically demonstrated that in a modern, successful economy health needs to be at the heart of every decision. From infrastructure to community, from early years to elder care, from workplaces to leisure and all points in between health should be built into our eco-system.

Our vision extends across both prevention and care. We want to see more people living long, healthy and productive lives; infrastructure designed for health; joined-up services delivered by and within the community, and new ways of working that bring benefits to community and individuals alike. In all of this we cannot and should not ignore the importance of prevention: there are huge differences in the major health challenges faced by people in different parts of the region, this inequality needs to be addressed.

Our work has been informed by four principles: Think holistically and systemically about health, build on existing success, consider investment not cost, and the answer is local.

Think holistically and systemically about health. We have to look at the determinants of health and wellbeing, and recognise social and geographical inequalities. We have noted the success elsewhere of systemic and holistic approaches such as 'Blue Zones' and the King's Fund work on Population Health, and we have suggested a range of policies across employment, housing, planning, infrastructure, education and transport that can contribute to better population health and equalities. We have drawn on previous reviews, in particular the CPIER Report and a study by ResPublica on the case for devolution of health in this region.

Build on, rather than disrupt, existing success. There are examples of local collaboration, integration and improvement across Cambridgeshire and Peterborough. We urge all concerned to acknowledge these and build on them rather than reorganising insensitively from above. For central government, the Combined Authority or the County Council that may mean staying out of the way and enabling those closest to the problems to tackle those problems. This does not mean leaving everything as it is, but empowering all parts of the system to reflect and build on what works well.

Consider investment, not cost. We have heard time and again that there are funding issues in the region that limit investment in innovation and delivery. And yet where we invest in innovation, like Healthy New Towns or Neighbourhood Cares, it delivers better outcomes. Similarly, prevention of illness is an investment in reducing pressure on health systems, not a cost. Public health spending is three to four times more productive for health than healthcare expenditure, and will over time reduce costs. With targeted expenditure, public health and behavioural interventions, the region can avoid a further decline into chronic health conditions that limit lives and hold back economic growth. The choice is between investment now, or more substantial cost later.

The answer is local. We need services and prevention strategies to be delivered by and within the community as much as possible. This starts with using the data we have in our region to understand the needs and contributions of individuals, households, and neighbourhoods; it should work through resourcing places and neighbourhoods and the local District Councils and third sector bodies that serve them. This will mean understanding services from the perspective of the user, not the provider. If we can agree this is the way forward, then there can be discussion about the organisational devolution and resource allocations that can best achieve this. It would be a mistake, however, to start with the structure.

The first aim of this report is to stimulate discussion that will lead to agreement on the objective and vision. We believe there is support for the vision and agenda described here, and a region full of the resources, abilities and opportunity to take it forward.

I would like to thank all those who contributed in sharing their thoughts with us and the Commissioners for their insight, dedication, and commitment throughout. I would also like to thank the Mayor and Combined Authority for their investment in this independent commission. My hope is that this report will ensure that we put health at the heart of every decision.

DR ANDY WOOD OBE DL

The Vision

THE VISION WE WANT TO WORK TOWARDS IS SIMPLE: IT STARTS WITH HEALTH AT THE CENTRE OF EVERY DECISION. The basis for decision-making across all areas of policy has to be: will this help people live healthier, longer, more productive and fulfilling lives?

We believe in a better future for the Combined Authority region where the entire functioning system is set up to promote the health of the people.

Our vision is informed by two priorities. One, to encourage health and wellbeing and invest in prevention, to reduce long term pressure on the health and care system. Two, to make sure that peoples experience of the health and social care system is user-friendly and joined-up. This means having a system that is integrated, and organised around the person, and not departmental priorities or targets.

Achieving the vision depends on the following interconnected elements.

- Infrastructure, planning, transport and education policies designed to promote health.
- Health and wellbeing services delivered by and in the community. As close to the service user as possible.
- Joined-up local health and care services that are easy to understand, reach and use. As close to the service user as possible.
- New ways of working and organising health care for the community and individuals. As close to the service user as possible.
- People being able to live long, healthy and productive lives.

Evidence from the region and around the world demonstrates that this can lead to:

SUSTAINABLE HEALTH AND CARE SYSTEMS

- A reduction in the pressure on acute and primary care.
- Less waste and red tape.
- Better training and self esteem for those working in the care sector.
- A stronger sense of ownership by those working in and around health and social care.

COMMUNITY RESILIENCE

- A better use of voluntary and neighbourhood resources.
- Greater resistance to future threats to health.
- A strengthening of local communities.

LOCAL AND PERSONAL OWNERSHIP OVER HEALTH

- People living happier, healthier lives.
- Lower incidence of diabetes, heart disease, cancer. and conditions associated with obesity.
- Less loneliness and isolation.

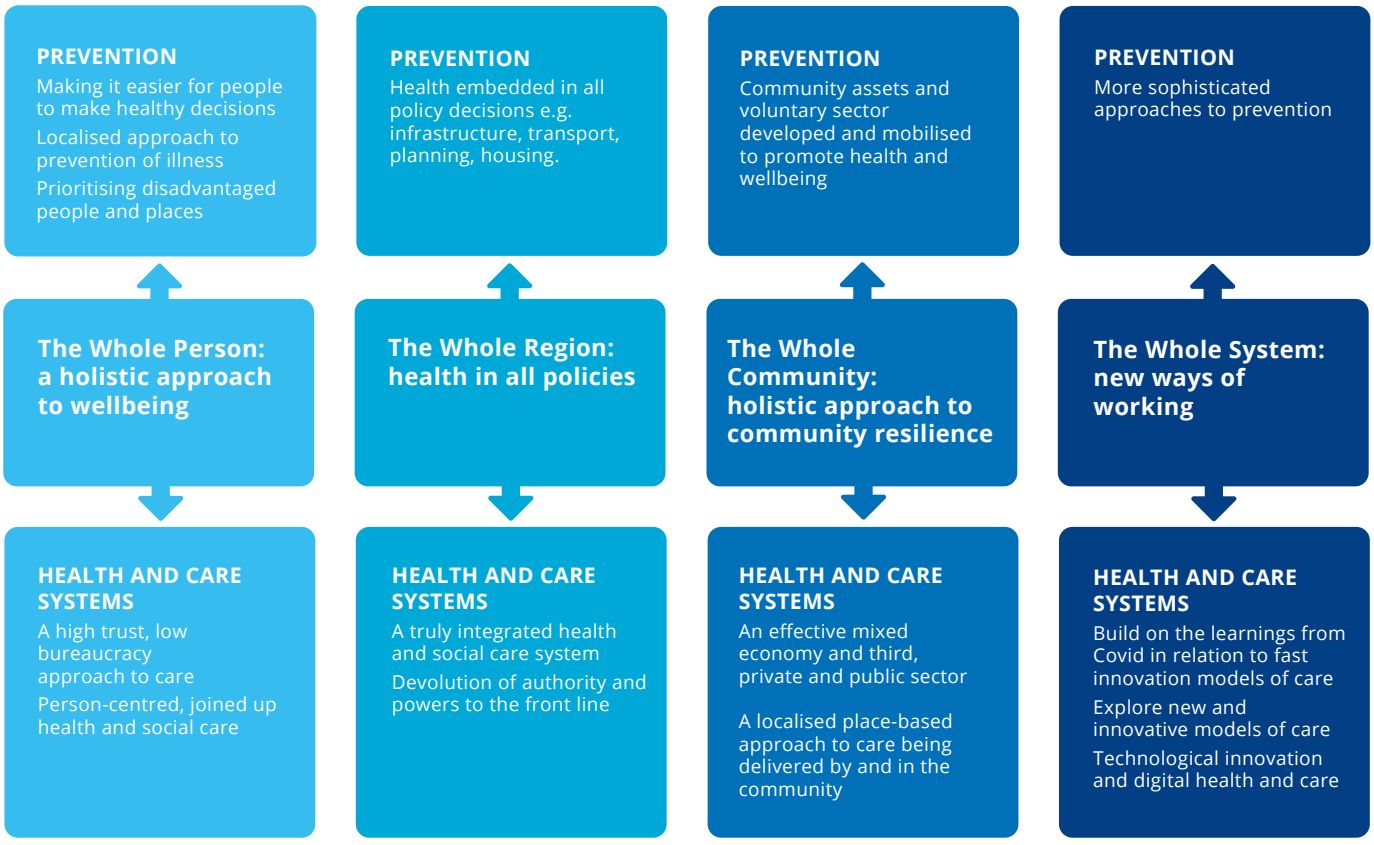
A SOLID FOUNDATION FOR SUSTAINABLE AND INCLUSIVE GROWTH

- A workforce less vulnerable to physical and mental ill-health.
- Increased productivity and reduced absenteeism.
- Reduction of social inequalities.

How can we achieve the vision?

To achieve the vision we need to focus on both prevention and better health and care systems, across four areas: The whole person, the whole community, the whole region and the whole system.

First there is the focus on health and the prevention of illness at the level of the individual, their family and household. Second, there is the focus on the resilience of the neighbourhood and community. Third, there is the perspective of regional and national government policy, and the opportunity to join together the potentially disparate influence of different specialised policies and departments. Fourth, there is the opportunity to improve each of the first three with new ideas, new ways of working and new technologies.



The Whole Person: holistic approach to wellbeing

"We need a shift in attitude towards people using their own and their community's resources to address their health needs, as well as a publicly-funded service people need more support, information, and resources in their local area" – Healthwatch Cambridgeshire and Peterborough[i]

Wisbech is within the top 20% of the most deprived areas in the country, and an estimated 33% of the population are from a migrant background and undertaking unskilled work. The 'Grow it, Cook it' project has educated over 80 families to grow their own vegetables and prepare food. They have also organised local health and wellbeing activities such as yoga, football and basketball, which help to increase exercise and reduce social isolation. These are targeted at factories and supermarkets to signpost workers who may benefit most from the activities.

STARTING WITH THE INDIVIDUAL

The commitment to put health at the heart of every decision starts with each and every one of us. It is not just a matter for councils and public bodies. It starts with the choices we make. People want to look after their own health, so it needs to be simpler and easier to make the right choices.

Across this region a quarter of adults are inactive and more than a third are not active enough to benefit their health.[ii] Nearly two thirds of people in the region carry excess weight.[iii] 78% of those infected and 62% of hospital deaths from Covid occurred in overweight or obese individuals.

A localised approach to prevention of illness must take into account social inequalities. Organisations like Cambridgeshire Insight have a huge amount of information about what is needed in each part of the region. To achieve inclusive growth, we need to bring the most disadvantaged areas up to the health and opportunity levels of the rest of the region. We need to use this to help people to help themselves.

Public health is more on the agenda than ever. As a result of Covid an approach that focuses on diet, exercise, sleep and relaxation will be more meaningful and attainable for people than before. There is no better time for co-ordinated and targeted information and support for self-help and healthier lifestyles. Local examples of good practice in this area that are embedded within the community, such as the Cambridge Food Hub, and the Diverse Communities Forum in Fenland, can be built upon.

This region has major employers that are leading in terms of their commitment to employee wellbeing. This can be reinforced, to mobilise the combined efforts of major employers in the region, both directly and through networks such as Cambridge Ahead and Opportunity Peterborough, to promote employee wellbeing.

CARE THAT IS JOINED UP AT THE POINT OF USE

"Patients don't much care where the care or provision comes from, they just want to be able to access them easily." – local provider

In its responses to this Commission, Healthwatch Cambridgeshire and Peterborough has repeatedly emphasised the need for care to be joined up at the point of use for patients. Care can seem service-centred rather than person-centred, particularly for mental health services and for those who have long term or multiple conditions. Wherever practical, the priority should be to make it easy for people to access and use.

"Our three-year digital strategy has happened in three months" – regional healthcare leader

The introduction of technology to facilitate virtual connection, consultation and care has established new patterns of working and helped users and providers of services. There are countless examples of digital change making care more efficient, especially for community teams.

A large part of the confusion for patients is the lack of shared information about their needs, what happens next in their care, and who is there to help. We have no lack of data in the system, but we need to be braver and more innovative about sharing it.

To ensure that everyone benefits from these innovations, it will be important to help people with low or no digital skills.

RECOMMENDATIONS

- The CPCA should identify and focus on 'opportunity areas' for health, particularly in the North of the region, diverting resources to the local council and communities to focus on prevention.
- Endorse the digital approach to health and care. Work with community and voluntary sector, and the education and skills agenda at CPCA, to map and increase digital access and literacy across the region.
- Equip local authorities with the data, resources and mandate to identify the largest health risks and operate relevant campaigns in partnership with relevant commissioning groups and public health bodies. Encourage partnerships with the private sector to draw on innovative approaches to prevention.
- Engage employers around their teams' health, particularly mental health, given its proven relationship with productivity, and to mitigate against the impact of the Covid response. Engage using the existing networks such as Cambridge Ahead and Opportunity Peterborough.
- The CPCA should work with relevant partners to explore ways of strengthening the local and regional supply chain of high-quality, locally-grown food. This should include growing and cooking at a local level. It could also include selling in local food outlets. Partnership arrangements should be discussed with retailers who would be sympathetic to the healthy food, good nutrition message.

The Whole Community: holistic approach to community resilience

"The Rough Sleepers Task and Targeting group in Peterborough brings together public services and voluntary organisations that support rough sleepers and the homeless, including police, probation, local hostels, night shelter, the drugs and alcohol unit, GPs and the voluntary sector. This approach works so effectively because it encourages collaboration, shared decision-making and open communication between bodies that provide care or support to individuals. We build plans together and share responsibility and risk"

Quote from discussion with a member of the Rough Sleepers Task and Targeting group

In the village of Gamlingay there appears to have been a reduction in demand for GP appointments on a Monday morning. Why? Because people in the village recognised that if some of those seeking help from GPs were offered more opportunities to meet others and feel valued, they would not need to make to make such demands of their GP.

In St. Ives, a resident who was recently widowed went from demanding considerable time from the local social work team, to being a fully engaged volunteer supporting that team's work in assisting other residents. This was as a result of a new social prescribing programme introduced with the help of the ground-breaking Neighbourhood Cares team set up by Cambridgeshire County Council.

THE IMPORTANCE OF COMMUNITY GROUPS AND VOLUNTARY ORGANISATIONS

We need health and care systems which are organised around and support our lives: which can reach us in our homes, support our families to care, and release the full potential of communities. The voluntary and community sector has a consistent track record of working in that way: holistic, long term, relational and locally rooted and can reach the whole community, think whole person and act for a whole lifetime.

A LOCALISED PLACE-BASED APPROACH TO CARE – BEING DELIVERED BY AND IN THE COMMUNITY

Building on the Think Communities approach already being adopted by local councils in their delivery of public services, and the lessons learned from community's response to Covid, care should be in and by the community as much as possible. Communities are the best places for people to receive care, and are also a key way of preventing people's needs being escalated into needing primary or acute care.

The Buurtzorg[iv] approach to home care has already been piloted in this region through the Cambridgeshire County Council Neighbourhood Cares project. The improved care comes from autonomy and empowerment to adjust care plans to personal needs. That said, there is significant evidence that, long term, across the system, this approach to care can and will make savings for acute care through prevention and de-escalation.

Even without direct involvement of the NHS, the programme was able to demonstrate high quality health outcomes, better self-reported quality of life for clients, the formation of new self-help groups and partnerships with local libraries and art groups. There was less demand for more specialised and expensive professional support. While the County Council made the investment, many of the benefits have accrued to the NHS and other services. The full benefits, including significant cost savings as well as better user experience, can only be achieved when the barriers between different services are broken down and budgets combined.

AN EFFECTIVE MIXED ECONOMY OF THIRD, PRIVATE AND PUBLIC SECTOR

We can be better in how we commission services in the community. Social value should become a fundamental part of health and care commissioning, service provision and regulation. In place of crude outsourcing this means delegation of tasks to social enterprises, mutuals, charities and private sector organisations that can pass a Trust Test that assesses their culture and alignment of purpose and values with public objectives.

THE IMPORTANCE OF LOCALISED APPROACHES

We have heard and seen countless examples of localised approaches to wellbeing: small scale, impactful initiatives that are in place to help people in the community. These need support and investment.

The excellent Health and Wellbeing Strategy[v] for the region includes the recommendation that health and wellbeing indicators be mapped at the local level to help to 'fine-tune' provision, targeting, and monitoring of campaigns and services.

Many health and social care professionals, together with third sector organisations, want to have the authority and resources to address issues that are relevant to local communities. The health concerns of those in Central Cambridge are different to those in the Fens. Activities to promote wellbeing need to be localised. The challenge faced is one of empowering the individual, the family, the community, the neighbourhood, district, city, town and parish councils to promote wellbeing that works.

RECOMMENDATIONS

- Embed and endorse a localised, mixed economy approach to care and wellbeing in the community – using public, private and third sector. Endorse innovative approaches to procurement to ensure these relationships are built well, such as the Trust Test to ensure appropriate outsourcing.
- Prioritise making local organisations - local authorities, district, city, town and parish, communities – the delivery mechanism for wellbeing strategies. Invest in them, acknowledging that investment does not always mean financial support. Encourage the use of innovative and sophisticated prevention approaches, including drawing on the vast resource of the private sector.
- Expand the Neighbourhood Cares initiative across the region, starting next with the 'opportunity areas' identified in Peterborough and in the Fens, and building on the learnings identified by the pilot. The full payback on this programme can only be appreciated once health and social care budgets are looked at together and this issue is dealt with below under New Ways of Working.

A Whole Region: health in all policies

This Midwestern city had high smoking rates and low activity levels, and they climbed out of a health and economic crisis with projected lifespans increased by nearly 3 years. This included:

- *$7.5 million in savings in annual health care costs for employers.*
- *2.9 years added to lifespans within one year of participating in the Blue Zones Project.*
- *The Downtown Streetscape revitalization has increased private investment, tourism, and the tax base.*

Blue Zones Project, MN.[vi]

HEALTH IN ALL POLICIES

At a high level, there are two ways that the CPCA can contribute to the health of the population through its approach. One is 'Business as Usual' – using the CPCA's existing powers to contribute to healthier living in healthier places. The other is to help to bring about a form of devolution of authority for health and social care that would make possible a localised and integrated approach, with combined budgets that free all concerned at the level of individual cities, districts and neighbourhoods to focus on prevention, shorten lines of communication and respond to local need.

When we asked those across the region what the Combined Authority could do to support health, many responses could be summarised with the words: 'Stay out of the way and don't make things more complicated than they already are'. Given the tangle of overlapping bodies with responsibility for health and social care this is understandable. The only reason for making a devolution bid to central government is if this opens the door to genuine localisation and simplification.

In the meantime, there is a major opportunity to put health at the centre of every decision made by, or influenced by, the Combined Authority.

A WHOLE HEALTH APPROACH

'Our health and wellbeing is shaped by much more than just health care. The places we live in affect our health in countless ways, including through the way a neighbourhood is designed, access to green spaces and the provision of good public transport. The social environment plays a key role too: strong social relationships or, conversely, stressful living conditions, can impact on our mental and physical health, and there is evidence that good urban design and planning can help to encourage positive interactions and improve health' - King's Fund, Creating Healthy Places[vii]

Health needs to be considered in all policy decisions from the outset. The Mayor and the Combined Authority currently have responsibility for a wide range of policy areas which include regional economic growth, housing; transport and connectivity; skills; public service delivery; tackling deprivation, and improving quality of life. Establishing this Commission already signals the Mayor and Combined Authority's commitment to the importance of health and social care to the economy and to the community.

Councils and public bodies influence the decisions each of us make. If there are no local fields on which children can play football, their wellbeing, and quite possibly their future lifestyle, is adversely affected. It is hard to make the right food choices if junk food is on our doorstep and healthy food is too expensive or inaccessible. If a city has more cycle lanes and less polluted air, then more of its citizens will make healthy transport choices. Health needs to be at the centre of infrastructure decisions.

The NHS 'Healthy New Town' initiatives and the building of 'Blue Zones' are two programmes that put health at the centre of decisions regarding public infrastructure, transport and town planning, and deliver effective approaches to population health and integrated care. In Northstowe, Cambridgeshire has one of the ten pioneering Healthy New Towns. Principles that underpin Healthy New Towns could inform every planning and policy decision made by every local authority in the region. For example, a focus on housing should also include an acknowledgement of the value of community-focussed, multigenerational housing. Parts of the region also need explicit focus on alleviating homelessness.

BLUE ZONES

Blue Zones are an example of how public health can be promoted by changing the area and community to nudge residents into healthy living. Elements include making roads, transportation and public spaces accessible. Having municipal entities and businesses promote activity and access to eating well, including restaurants, schools, workplaces and shopping areas. Fostering social networks that promote healthy habits. Designing new homes that encourage movement and community. "Blue Zone" communities help residents focus on their "inner selves", encouraging people to reduce stress and enable a sense of purpose.

These are examples of the numerous interventions that could be adopted by the CPCA. Responses to this Commission in this area included: Helping the Primary Care Networks and Neighbourhood Cares programmes by ensuring that they have premises, involving health and care leaders and Healthwatch in the planning process to ensure patient and peoples' voices are heard. Empty high street premises could be made available for health hubs, community meeting points and volunteer co-ordination centres, giving physical shape to resilient communities of the future. When future transport routes are planned it is important that they take account of the needs of those travelling to surgeries and hospitals. These are all approaches within the current gift of the CPCA.

A DEVOLUTION BID

"If we were to sit the public down and explain to them how tribal Health and Local Government are, they wouldn't believe us."

"It's not about asking for a blank cheque. It's about asking for the power to spend the money in the way that is most appropriate to us".

"We have the greatest need to drive down costs and to save money. This gives us a reason for doing it, a real need for change on a major scale." – local council leader

Through the work of the Commission our impression is of people and organisations that are open to change, keenly aware of the need to integrate, and of the drag factor associated with duplication. The response to the Covid crisis has shown what can be done: traditional boundaries have disappeared and the focus has been on working together towards a common objective. The leaders involved in that collaboration want to find ways of consolidating and not abandoning this progress. Yet structures get in the way and the pace of change slowed. Somehow a way has to be found to create a combined budget at the local level.

The framing of the Cambridgeshire and Peterborough devolution settlement allows for dialogue with the Government on the devolution of health and social care funding. Devolution could open the door to collaboration across the region in a programme that enhances the health of its population and becomes an exemplar for a totally new way of approaching health – with substantial impacts in the short, medium and long term.

The major advantage of devolution for health and social care would be the pooling of budgets, which would reduce the friction that occurs when health and care overlap and intersect. It would allow spending to be defined at the local level, and funding (re)directed to prevention strategies and opportunity areas. It would make it easier to invest in prevention, which is a key factor in driving down the pressure on health systems.

It would also reduce governance duplication and bureaucracy, and speed up the integration of services. Most of all, it would ensure that those closest to the problems have more influence on the solutions.

Any devolved approach must work to devolve funding and power as close to the front line as is possible. It must not just be place-based, but local and community-led. The outcome should not be to concentrate responsibility for health up or into the Combined Authority. It is about focusing on local needs across the Combined Authority region. Authority needs delegating to those with the knowledge, skills and experience that put them closest to the patient – in short to specialists in local care provision.

RECOMMENDATIONS

- Make health a strategic measure and consideration in all aspects of the Combined Authority's strategy, with particular focus on: long term investment in prevention and building infrastructure that enables health and social care to be more integrated and community-based. Use learnings from the Healthy New Towns (HNT) and Blue Zones. Commit to developing more Healthy New Towns, and adopting principles of HNT for development in existing places. Encourage the development of multi-generational housing programmes.
- The CPCA should be briefed regularly on the relevant indicators identified by the local Health and Wellbeing Board to inform all policies that can have an impact on the health of individuals and the resilience of communities. The design of any future decision-making structures should ensure that these indicators are agreed and reviewed regularly.
- CPCA to take the lead, after consultation with the CCG, STP, and Public Service Board in seeking a combined health and social care budget, with both capital and revenue elements, that would be delegated to localised teams and to local authorities. Building on collaboration experienced during the crisis the new settlement would be designed to make such collaboration a way of life with a single budget covering spending in the region.

The devolution bid must commit to:

- Putting funding and powers as close to the front line as possible.
- Empowering and funding local authorities and the communities as the best delivery model for prevention approaches.
- Pool the budgets and authorise the CCG and STP to collaborate on delivery of health and social care, with requirement to localise as much as possible (e.g. through use of Neighbourhood Cares model of care).
- Rationalise duplication of bodies and oversight.

A Whole System: new ways of working and organising

A crisis can bring real and lasting change.

The Commission was asked to deal, in particular, with best practice in the UK and globally, to consider new ideas that may be of value in improving services in the region.

NEW MODELS OF CARE ORGANISATION

Around the world there are excellent models which offer the promise of better value for money, services that are better at prevention and better focused on the needs of the individual user. Buurtzog is a Dutch social enterprise that has caused a revolution in neighbourhood nursing and is starting to make a difference to the care system in the UK – including the Neighbourhood Cares programmes in St Ives and Soham. This approach to care can and will make savings for acute care through prevention and de-escalation. We also believe that if the region were to expand the use of this model it could increase employment in the in the short and long term, as these roles attract a wider range of applicants and report high levels of job satisfaction and empowerment.

VALUING CARE TEAMS AND ENHANCING THEIR SKILLS

Using neighbourhood models of care helps to create the need and the opportunity already recognised by the Mayor to make a step-change in the skill levels of care workers. Outside a crisis, such empowerment will need to go hand in hand with higher levels of training and development.

The pandemic was a reminder of the growing crisis in social care. There is a need for a major investment in skills for carers and employment in caring roles, and this will be especially helpful in parts of the region that face unemployment. The announcement in July 2020 of the future creation of a university in Peterborough and its focus on health ties the health and skills agendas together even more strongly.

NEW MODELS OF FUNDING

How social care is funded is a key question raised when we talk about care models, and there is potential to be more ambitious and creative. Responses to this Commission suggested a Care Tax – something similar is being discussed at central government level at present – and suggested an offset of Council Tax for families that take care of elderly relatives in their homes.

BUILDING ON COVID

"People are so much more accepting and willing to try things, and it feels more like a collective rather than pulling against each other."

"Now that we know what can be achieved when we work together, it will be hard to go back to the old ways of doing things"

The evidence from our discussions with people in the front line of the Covid crisis is that their effectiveness is enhanced when multiple national targets and departmental rivalries are set aside and the constraints of budget are removed. This does present an opportunity to be bolder. There is also the risk of great disillusionment if this collaborative momentum is allowed to falter.

Covid also showed how important a community response was. The answers in the most part that have worked have been local. The 'Think Communities' approach was taken when taking care of people across the region. New teams were put together and communication was more frequent and more productive. One participant told us that "everyone being out of their comfort zone has allowed greater collaboration and less defensiveness when working together. There is much less ownership of ideas and more motivation to support each other."

As the UK Government, the Department of Health, and all other decision makers contemplate the best way forward, we would urge them to look at the problem as these front-line operators have described it, and to assess all plans against these criteria:

Will this change make it easier or harder for people at local level to use their own judgement?

How do we re-organise in ways that help them to use all their energies to improve population health?

RECOMMENDATIONS

- Develop and implement a holistic strategy designed to put health at the heart of every decision across all its areas of policy.
- Consider the appointment of a Health Champion at Director level within CPCA to work collaboratively with local authorities and all the statutory and non-statutory health and social care bodies to help realise the ambitions described in this report. The person appointed must have a track record of demonstrating a partnership approach and the ability to listen and exercise influence across boundaries. Success in the role would result in Cambridgeshire and Peterborough becoming a national leader in health and care.
- Build on existing Further Education and Higher Education activity in the region to create new pathways of education and development and a growing supply of home-grown skills to health and social care. Build on skills and employment opportunity, invest in career paths into and within care.
- Formalise the learnings from Covid as they relate to the delivery of public services. This should include:
  - The better collaboration and working of health and care systems.
  - Build on the success of projects such as 'Neighbourhood Cares' and approaches such as 'Think Communities' empowering communities.
  - Rationalisation of governance: use the Covid response as an opportunity to rationalise and simplify boards, bodies, identify duplications of agendas, people and consolidate into more effective and efficient Governance models.
  - Put emphasis on the CCG, STP and Public Service Board and Combined Authority being aligned, not just co-operative.
  - Take advantage of the recent technological innovation and its use in health and social care, brought about by the Covid crisis.

Conclusion

It has always been understood that the economy provides the resources on which public services such as health and social care depend. Until recently, less attention has been paid to the corresponding reality which the Covid crisis has impressed on us all: without health in a community, or a region, or a nation there can be little progress in wealth creation. Health and wealth are inextricable.

Having spent our time over two years listening to and learning from practitioners and users here in the region, we are clear that we are at a unique moment. There is the opportunity to build on the imagination and agility that has been shown across health and social care in the crisis. We can use this opportunity to simplify the way things are done and shorten lines of communication; to eliminate unnecessary boundaries; to ensure that services are joined-up and simple for users to reach and understand and to make better use of technology to achieve this.

Our final report charts a route - which can be taken in Cambridgeshire and Peterborough, and more widely – towards a healthier population who can, as a result, be a wealthier one.

The report focuses in particular on the scope for bringing services closer to the people and communities they serve, in individual places.

The report also addresses how formal delegation of more powers to the region might help to open the door to greater wealth and health. Yet the ideas presented here do not rely on any particular decision-making structure. If we have learned one thing from the crisis, it is that when health professionals, communities, and government work together applying common sense towards a common objective, then rapid progress can be achieved regardless of structural obstacles. What matters most is a clear sense of purpose, destination, and the combined determination of all involved to get there. Only when there is some level of agreement on the objective does it makes sense to go into detail on the questions of structure. We present in this report a vision for health and social care in the region, and one that can be achieved through focusing on both prevention and better services, across four pillars: the whole person, the whole community, a whole health policy, and the whole system.

This report recommends the radical integration not only of health and care but of all the major contributors to health within the Cambridgeshire and Peterborough area. This involves an unprecedented focus on health and healthier lifestyles as the foundation of wealth and well-being for local populations. Crucially, we recommend that the focus for a devolution bid has, as a key design feature, not only the integration of health and care but a more prominent place-shaping and community development role for councils. This means coordination and budgetary responsibility being devolved to district and city councils for them to work locally with service providers. This approach commits to delivering through services organised as close to the service user as possible, and putting health at the heart of every decision.

FULL REPORT

CAMBRIDGESHIRE AND PETERBOROUGH INDEPENDENT COMMISSION FOR PUBLIC SERVICE REFORM

November 2020

The Whole Person: holistic approach to wellbeing

"We need a shift in attitude towards people using their own and their community's resources to address their health needs, as well as a publicly-funded service. People need more support, information, and resources in their local area"
– Healthwatch Cambridgeshire and Peterborough[i]

Wisbech is within the top 20% of the most deprived areas in the country, and an estimated 33% of the population are from a migrant background and undertaking unskilled work. The 'Grow it, Cook it' project has educated over 80 families to grow their own vegetables and prepare food. It has also organised local health and wellbeing activities such as yoga, football and basketball, which help to increase exercise and reduce social isolation. These are targeted at factories and supermarkets to signpost workers who may benefit most from the activities.

Our final report is split into four key areas: the whole person, the whole community, the whole region, and the whole system. For each of these parts we focus on how prevention agenda can be increased and accelerated, and how the health and care system can be better. We start here with the individual: how can we design and further a health and social care system that starts with the individual, and is truly person-centred?

STARTING WITH THE INDIVIDUAL

The commitment to put health at the heart of every decision starts with each and every one of us. It is not just a matter for councils and public bodies. It starts with the choices we make. People want to look after their own health, so it needs to be simpler and easier to make the right choices, whether that be through social pressures, planning, education or polices.

Across this region a quarter of adults are inactive and more than a third are not active enough to benefit their health[i]. Nearly two thirds of people in the region carry excess weight. 78% of those infected and 62% of hospital deaths from Covid occurred in overweight or obese individuals.

Most people want to be able to look after their own health – but to do this, they need the best and clearest information possible, and they need it to be simple and easy to make the right choices. Where it is harder, more expensive and against social norms, then real change will take longer. The job of the regional authority, therefore, is to help people help themselves, and promote personal independence – and to make sure nobody is restricted from looking after themselves by their situation or circumstances.

Healthwatch in its annual survey identified common themes in their feedback from patients: people are interested in self-help and would like more support to access information and appropriate services to help them keep well, but people often have to look for support themselves, sometimes whilst coping with illness or another's illness.[ii] They often find information fragmented across lots of different places, often not current, and often not accessible. In a review of GP websites in 2020 Healthwatch Cambridgeshire and Peterborough found that of the 98 GP websites in the region, half did not have the latest Covid guidance for the public, only 22 had access to information about changes to cancer services, and two out of three websites did not have good examples of accessible information for patients with sensory loss or learning disabilities.

HEALTHWATCH CAMBRIDGESHIRE AND PETERBOROUGH, PRIORITY 1 (2020 STRATEGY)

- Identify opportunities to improve health information with an emphasis on health inequalities.
- Explain self-care and promote ways in which people can take care of their own health needs.
- Develop and promote initiatives that help people to help themselves, including information, training and skills development.

Public health is more on the agenda than ever. The impact of the coronavirus (Covid) pandemic has put public health at the front of everyone's minds. It has highlighted to us how central health is to the success of a society. It has put individual responsibility for health at the forefront, with many people living in lockdown embracing new healthful activities like home-cooking, exercise and sleep. And it has thrown into relief how inextricably connected physical and mental health really are. A co-ordinated and targeted information and support for self-help and healthier lifestyles to build on this, could be hugely impactful. We also need to heighten people's awareness of preventative changes they can make before a health scare, by which time it can be too late.

There is now the opportunity to build on local examples of good practice in this area that are embedded within the community, such as the Cambridge Food Hub, and the Diverse Communities Forum in Fenland. These are expanded upon below, in the section 'The Whole Community'. This region also has major employers that are leading in terms of their commitment to employee wellbeing. Further impact can be made by mobilising the combined efforts of major employers in the region, both directly and through networks such as Cambridge Ahead and Opportunity Peterborough, to promote employee wellbeing.

A PREVENTION APPROACH

This focus on population health as a way to reduce impact on acute services is not a new idea. The NHS five-year review[iii] states that the best course of action to address pressure on healthcare is a radical upgrade in prevention and public health; it was emphasised in the Government's 2019 Green Paper[iv] on prevention, and again in the All-Party Parliamentary Group (APPG) for Longevity's final report in early 2020.[v]

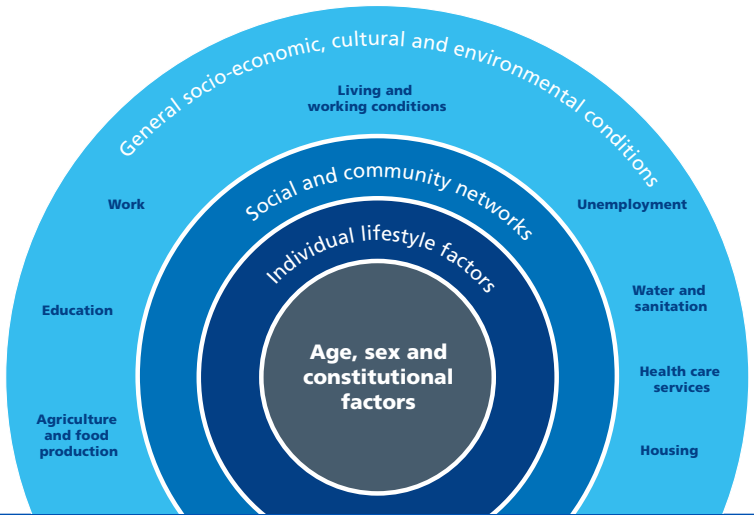
We have seen since then from the impact of the coronavirus just how damaging co-morbidities can be: 78% of those infected and 62% of those who died in hospital from Covid were overweight or obese, while only 10% of those suffering severe symptoms of Covid did not have any other co-morbidities.[vi]

We believe that to support an inclusive growth strategy and an integrated approach to health and social care, the region can and should also prioritise prevention of illness across all parts of the system. This means taking a population health approach.

Population health is an approach that focuses on improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It means prioritising the wider determinants of health and wellbeing. Many of these determinants are not part of what is usually considered healthcare. It means individuals and organisations across various domains accepting a degree of collective responsibility for protecting and promoting health and wellbeing.

As a nation, our spending on health and social care is currently concentrated in a health system which, although important, is responsible for a relatively small proportion of health outcomes, and just one aspect of that which drives the health of a population. Research by the Centre for Health Economics has outlined the opportunity cost that kicks in when spending is focused on illness rather than prevention. Their analysis shows that public health expenditure is three to four times more productive than healthcare expenditure on improving public health.[vii]

THE KING'S FUND: A VISION FOR POPULATION HEALTH



The Kings Fund diagram on the previous page outlines the determinants of health, illuminating what needs to be included in a population health approach. In the outer circle (most fundamental) are agriculture and food production, education, work, living and working conditions, unemployment, water and sanitation, health care services and housing. Next inward come social and community networks, and within that, individual lifestyle factors. At the centre are age, sex and constitutional factors. If we understand the implications for health of all these factors, it becomes easier to identify all the ways that decision-making can improve people's health. To put it another way, if we can get the outer circle right, we can help to influence the inner circles.

LOCALISED APPROACH TO PREVENTION

"We need a shift in attitude towards people using their own and their communities resources to address their health needs, as well as a publicly-funded service. People need more support, information, and resources in their local area." Healthwatch Cambridgeshire and Peterborough 2020 strategy [viii]

One of the key messages that came through in the work of this Commission was that organisations involved in health value the power of being able to address particular issues that are relevant to local communities. Whether local council, charity provider or oversight organisaiton – there is widespread recognition that, for instance, people in Central Cambridge and people in the Fens have different dominant health concerns. As outlined in this Commission's interim report the region would benefit hugely from being able to dial-up and dial-down priorities across different parts of the region.

There is abundant evidence that while both health and social care needs need to be governed by clear national policies, its delivery needs to be co-ordinated at community and local government level. For example, key public health functions should be calibrated at community and local government level, rather than at a centralised or NHS level. The lessons from "Blue Zones" – regions and cities that have made health their core priority and seen results in terms of longevity of (healthy) life, which we discuss later in this report – are that the most effective change programmes need to focus on the 'life radius': the areas and environment where people spend most of their lives.

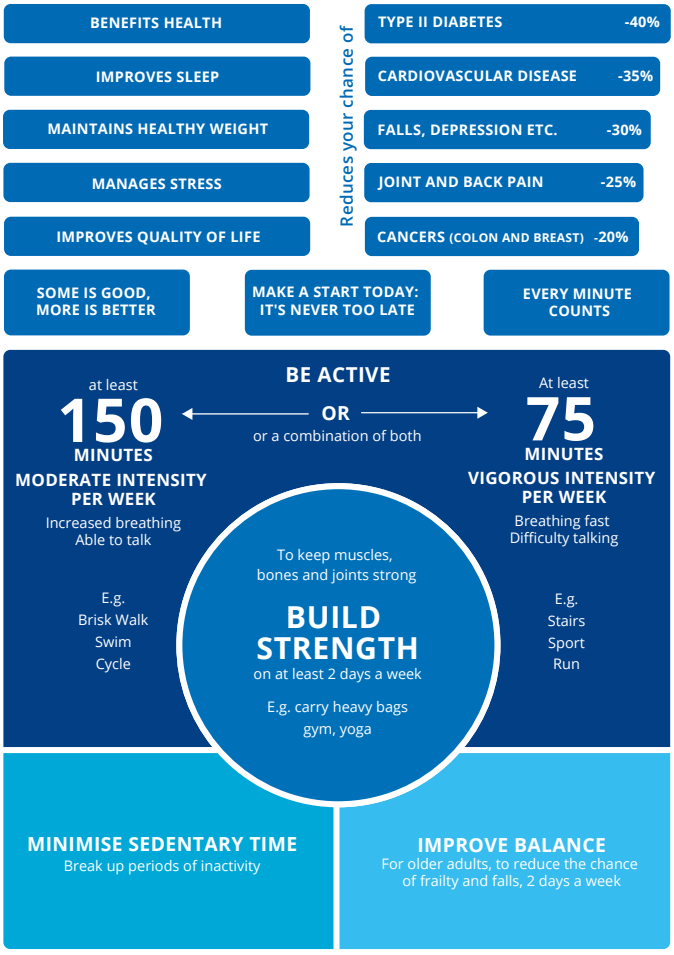
Within the region there is a great deal of localised data available that can help to identify what needs present themselves where, or how spending should be prioritised. This is already being used to an extent, but there could be greater ambition in how this is brought together. Types of data include: socio-demographic data, education rates, deprivation, hospital attendance rates, transport, crime statistics, income and employment data, disability rates, smoking rates. Much of this data is collected and collated by Cambridgeshire Insight. The Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy 2020-2024 (draft for consultation)[ix] draws on some of this data, and also recommends that health and wellbeing indicators be mapped at the local level to help "fine-tune" provision, and the targeting and monitoring of campaigns and services – including via the STP – in an effort to improve service co-ordination and improve people's day-to-day health.

A localised approach to prevention and wellbeing also allows targets to be set that are appropriate and focus efforts on things that are relevant to each area, identifying opportunity areas where the most potential health gains can be made, and generate specific, impactful interventions with a broad view of health.

EXAMPLE: PROMOTING ACTIVITY AND EXERCISE

Lack of physical activity is one of the "big four" causes of preventable ill health, along with smoking, poor nutrition and excessive alcohol consumption. Inactivity affects the largest proportion of the population – and yet, of the four, it is the least well known among the general public. Physical activity reduces the risk of developing several long-term health conditions – including type 2 diabetes, cardiovascular disease, falls, joint and back pain, colon and breast cancer – by up to 40%. It also helps to reduce the likelihood and impact of some mental health conditions such as depression.

PHYSICAL ACTIVITY FOR ADULTS AND OLDER ADULTS



Benefits to exercise and physical activity for adults: adapted from a Living Sport poster.

While an issue for many parts of the UK, across Cambridgeshire and Peterborough, a quarter of adults are still inactive, and more than a third are not active enough to benefit their health.[x] Adult activity is lower in Fenland, East Cambridgeshire and Huntingdonshire than other parts of the region with children's activity lower in Fenland and South Cambridgeshire. Across Cambridgeshire and Peterborough, only 6.8% of children and young people meet physical activity guidelines of 60 minutes per day.

At the same time, the region has examples of success and good practice that could be expanded into other parts of the region. The region as a whole has high levels of active travel, while Cambridgeshire has the highest rates of cycling for travel in the country.[xi] Local charity Living Sport works to improve the health, happiness and wellbeing of the people of Cambridgeshire and Peterborough by inspiring them to get active. For example, it works with a range of partners including Cambridgeshire & Peterborough Public Health and Everyone Health to promote a County Healthy Schools Award. They also have initiatives in place to help improve levels of physical activity and promote better mental health. The Nene Park Trust is another example: a local charity working to increase wellbeing through the maintenance of the park, offering outdoor activities and educational opportunites. These are just two examples of localised, third sector organisations that are driving impact on health in the region.

RECOMMENDATIONS:

- The CPCA should endorse a localised approach to prevention to achieve population health. This should include:
- Equipping local authorities with the data, resources and mandate to identify the largest health risks and operate relevant campaigns in partnership with relevant commissioning groups and public health bodies.
- Encourage partnerships with the private sector to draw on innovative approaches to prevention.
- Working with relevant partners to explore ways of strengthening the local and regional supply chain of high-quality, locally-grown food. This should include growing and cooking at a local level. It could also include selling in local food outlets. Partnership arrangements should be discussed with retailers who would be sympathetic to the healthy food, good nutrition message.

REDUCING INEQUALITY: PRIORITISING DISADVANTAGED PEOPLE AND PLACES

"There needs to be concerted action on health inequalities as part of efforts to create healthy places, informed by data on the specific health needs of local communities. Health-promoting infrastructure, activities and opportunities need to be accessible to all, with a targeted focus on groups with the poorest health outcomes."
– King's Fund, Learnings from Healthy New Towns[xii]

A localised approach also allows the region to measure and take into account social and health inequalities. Differences in health status can be determined by a range of factors, such as socio-economic status, education, housing, locality, or personal characteristics (sex, ethnicity, disability). Some particular groups experience specific complex needs.

For this region to achieve truly inclusive growth, it will need to bring the most disadvantaged areas up to the health levels of the rest of the region. This Commission echoes the conclusion of the Cambridgeshire and Peterborough Independent Economic Review (CPIER)[xiii] by recommending that the Cambridgeshire and Peterborough Combined Authority (CPCA) identify the north of the region as an "opportunity area for health", and focus public health efforts in that region. It was also highlighted by many responses to this Commission that it is not only the north of the region that needs focus, and there are pockets of deprivation (both social and health) across the region. The City of Cambridge is for example one of the most unequal in England.[xiv] These areas of deprivation are likely to be the worst affected by the potential of economic downturn as a result of the coronavirus pandemic, and the need to identify and support these opportunity areas has never been more vital.

In many ways, the Cambridgeshire and Peterborough region is defined by its differences, and acts as a reflection of the UK as a whole. While much of the region is affluent, with abundant innovation and wealth as well as one of the world's best universities, there are also cities and towns that are amongst the 20% most deprived in the country. These inequalities are reproduced in the region's health needs. While nearly two-thirds of Cambridgeshire and Peterborough adults carry excess weight, East Cambridgeshire and Fenland have levels above the national average. While obesity levels across the region are generally lower than the English average, they are higher in Peterborough and Fenland. Adult physical activity levels are similar to England, but levels of activity in Peterborough are significantly worse. Adult smoking is statistically similar to the national average in Cambridgeshire and Peterborough collectively, but Fenland has a notably high proportion of smokers among its population.

Even in relatively affluent Cambridge, the picture is still mixed. South Cambridgeshire has the best profile in relation to wider determinants of health and well-being[xv] and the most common cause of years of life lost to premature death is heart attack, followed by stroke, chronic lung disease, dementia and self-harm. In areas with high levels of employment in fast-paced, high-pressure industries, we also see high rates of burnout, anxiety, and stress. Within Cambridgeshire, while the highest rates for deprivation are in Fenland, when deprivation scores are mapped by Lower Super Output Area (neighbourhoods of around 1500 residents) it is possible to identify areas of high deprivation in Cambridge City and Huntingdon.[xvi]

RECOMMENDATION: The CPCA should identify and focus on 'opportunity areas' for health, particularly in the North of the region, diverting resources to the local council and communities to focus on prevention.

THE ROLE OF EMPLOYERS AND LOCAL BUSINESSES

"This region has some of the brightest academic institutions in the world. We have the biggest biomedical campus in Europe. We have some of the biggest employers. What is their role in the community? How are they contributing to health?"
- Health leader

In order to truly embed a "whole person" approach to health in this region, employers must be included in acknowledging their role in improving the wellbeing of their employees. This too echoes the CPIER recommendation that "The Combined Authority should support and expand existing initiatives to work with employers and stakeholders of all sizes to gather more intelligence on the issue of workplace health and to frame recommendations for action".[xvii]

There is potential to be much more ambitious regarding the involvement of employers in the health of the people. Employee wellbeing is not simply an optional extra; it is a core part of companies' strategic direction, and those who engage with it wholeheartedly will see dividends in terms of productivity as well as employee attraction, retention and loyalty.

This Commission outlined in our interim report the huge potential that could come from engaging employers on health and wellbeing. There is huge appetite in the south of the region, with the East of England Health Work and Prosperity Group, Public Health England and Cambridge Ahead all undergoing research, innovation and intervention projects into workplace wellbeing.

The East of England Health, Work and Prosperity group aims to provide a strategic regional platform, to inform, learn, influence and enable regional and local action that improves employee health and wellbeing, and employment and health outcomes for those out of work. These combined will improve productivity and prosperity in the East of England. The group is co-chaired by Dame Carol Black, Government Adviser on Health and Work and Professor Aliko Ahmed, Centre Director, Public Health England – East of England. Support is provided by Val Thomas, Consultant in Public Health at Cambridgeshire County Council & Peterborough City Council and Neil Wood, Health & Wellbeing Programme Manager at Public Health England through their roles as co-chairs of the regional Worklessness, Health and Work Network.

The region has many exemplar employers in this area, most notably Anglian Water, which has won numerous accolades for its work on employee wellbeing. When it made a concerted effort to focus on employee wellbeing in 2005, in part to reduce the cost of medical cover and sickness days, the result was a reduction in workplace accidents and a significant return on investment. Since then, the company has been at the forefront of making wellbeing a core part of the employer-employee relationship, including their more recent work on mental health. Huntingdon District Council similarly adopted a workforce wellbeing focus in 2019/20, introducing a mental health first aider and an organisation-wide focus on reducing stress. As a result, it reduced its absenteeism rates, and saw an increase in productivity and engagement. Many of the region's hospitals also have employee wellbeing schemes, and in this they have been supported by local communities during the coronavirus pandemic.

The lesson of these examples is that resources devoted to employees' physical and mental health is not a sunk cost; it is an investment that will pay dividends.

Cambridge Ahead, a business and academic membership organisation, recently commissioned a project to examine Quality of Life drivers in the region to better its understanding of what the typical employee of a Cambridge business feels about their current quality of life. The aim is to define a framework for quality of life that can contribute towards local decision-making, with a particular focus on the role of employers. This framework could be a useful resource for helping to identify what areas employers should prioritise.

In the north of the region we found less examples of collaborative action relating to employer wellbeing. While there are some large employers with significant employee wellbeing agendas - the BGL Group Limited, Coloplast, Bauer Media Group and Perkins have all been acknowledged for their work in this area – there is not as obvious a place for employers to be brought together and share best practice. There may be good reasons for this, but it is important for the CPCA to encourage and support those businesses who have invested effort in this area. There is also a need for the resources that exist in the south of the region to include and be used by the organisations in the north, and organisations to be encouraged to do so.

RECOMMENDATION: The CPCA should engage employers around their teams' health, particularly mental health, given its proven relationship with productivity.

CARE THAT IS JOINED UP AT THE POINT OF USE

"Patients don't much care where the care or provision comes from, they just want to be able to access them easily." – local provider

"If we were to sit the public down and explain to them how tribal Health and Local Government are, they wouldn't believe us." – Local government leader

In its responses to this Commission, Healthwatch Cambridgeshire and Peterborough has repeatedly emphasised the need for care to be joined up at the point of use for patients. Care can seem service-centred rather than person-centred, particularly for mental health services and for those who have long term or multiple conditions. Wherever practical, the priority should be to make it easy for people to access and use.

We discuss later in this report how care can be made better integrated, more person centred, and as much as possible delivered in and by the community. We also outline the current work being done to integrate approaches, and the potential for this to be accelerated.

Mental health is a particularly important issue both nationally and locally. While mental ill-health is on the rise, provision of support is overstretched and underfunded. In 2018 Healthwatch found that 52% of respondents felt negatively about their experience of getting help for a mental health condition (for comparison, 21% of heart and lung patients and 18% of cancer patients had negative responses).

In Cambridgeshire and Peterborough there is in particular an issue with access to mental health services for people who are neither low or high risk. Healthwatch Cambridgeshire and Peterborough note that many patients report only being able to access services when they are in crisis (and many stories of people not being able to access services even when they are in crisis). They have identified issues across four key themes: (lack of) access to services, unclear pathways, opportunities for more user involvement, shortages of staff and funding.[xix] The need for services and support to be designed with the patient in mind rather than the systems could not be clearer than where it relates to mental health support. This is an area where people regularly fall through the cracks in provision. Perhaps even more so than physical health, in mental health we know that early intervention is the best way to prevent illness, but there is a high threshold for providing support.

RECOMMENDATION: All plans for health and social care for the future should be focused on integration, and ensuring care is joined up at the point of use.

The Whole Community: holistic approach to community resilience

In the village of Gamlingay there appears to have been a reduction in demand for GP appointments on a Monday morning. Why? Because people in the village recognised that if some of those seeking help from GP's were offered more opportunities to meet others and feel valued, they would not need to make such demands of their GP. By putting in ways for people to meet on a Friday afternoon, they took pressure off Primary Services.

In St. Ives, a resident who was recently widowed went from demanding considerable time from the local social work team, to being a fully engaged volunteer supporting that team's work in assisting other residents. This was as a result of a new social prescribing programme introduced with the help of the ground-breaking Neighbourhood Cares team set up by Cambridgeshire County Council.

We have outlined in the previous section the importance of seeing prevention and the health and care system through the eyes of the individual; taking a truly person-centred approach. We now focus on the role of the community in furthering a prevention approach, and on providing health and care in and by the community. Our belief is that the answer is, as much as possible, to take a localised approach.

THE IMPORTANCE OF COMMUNITY

Wellbeing is the goal for prevention approaches and for those that deliver health and social care provisions. We will all draw upon primary, acute or specialist health services at various points in our lives and we want to find them available, caring and well run when we do. Particularly for people with lifelong disabilities, the older population or those with long term health conditions and support needs, our dreams remain rooted in living well at home as part of welcoming, inclusive communities. People want to be able to access the services that support wellbeing as close to home as possible.

Achieving that goal requires health and care systems which are organised around and support our lives, and that are delivered by and within the community as much as is possible, and in partnerships with voluntary organisations. This is consistent with both the 2014 NHS Five-Year Forward View, which outlined a commitment to developing stronger partnerships with Voluntary Community and Social Enterprise organisations as part of a 'new relationship between patients and communities', and the 2019 Long Term Plan that focused on the need for population health and integrated care systems.

Earlier in this report we outlined the vital role of personal empowerment; this must be enabled by the local community. The voluntary and community sector has a consistent track record of working in that way – holistic, long-term, relational, and locally rooted, thinking whole person and acting whole lifetime. It also became clear to the commission in our conversations across the region, that localised approaches to wellbeing and prevention of illness are in most cases, the most effective. While there are aspects that are regional and national, a holistic approach is best delivered when it is localised.

The People and Communities Board, part of the governance of the NHS Five Year Forward View, developed six principles for implementing the NHS Five Year Forward View, which local health systems were asked to build on when developing Sustainability and Transformation Plans. These six principles are as follows:

1. Care and support are person-centred: personalised, coordinated, and empowering.
2. Services are created in partnership with citizens and communities.
3. Focus is on equality and narrowing inequalities.
4. Carers are identified, supported and involved.
5. Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers.
6. Volunteering and social action are recognised as key enablers.

These principles are valuable for our approach to health and care services. They are most successful when they are co-produced, focussed on wellbeing, and value individuals' and communities' capacities. There should be greater co-production with people who use services and their families at every level of the health and care system. NHS England needs to ensure that its guidance on STPs to require local health and care systems to draw upon the six principles created to support the delivery of long-term plans is being heeded. At both national and local level, the voluntary, community and statutory sectors need each other. Each brings its own kind of expertise and its own kind of resources and each has much more to do to ensure citizens are included and empowered from the earliest stage and throughout. It is time we brought our sectors together to create the local and national health and care systems which we all need to achieve wellbeing.

THE IMPORTANCE OF LOCALISED APPROACHES

The Camerados movement is a voluntary organisation that sets up Public Living Rooms, in hospitals, universities, workplaces and public spaces. Their motto – the answer to our problems is each other – sums up the role that we each can play in supporting each other in communities, improving wellbeing and mental health through the building of human-led community spaces.[xx]

THINK COMMUNITIES APPROACH

Our belief in a community approach builds on the current way of working we have seen in public services in Cambridgeshire and Peterborough, and we have found widespread support for a community-led approach to health and wellbeing.

An example of where this is already happening is through the local councils' Think Communities approach, which is both a way of working for public services, and part of the integration of Primary Care Networks and Integrated Neighbourhoods. Think Communities aims to encourage individuals to look after themselves and their own community better, and to ensure as much as possible that where they need to access services, they do so within the community. It takes "People, Places and Systems" approach to public services, with a focus on building relationships and making services more person centred. It also emphasises that no two local communities are exactly the same, and that the health needs, skills, and assets within different communities will vary widely. It also means moving out into the community to get staff closer to people.

In practice this includes:

- Helping communities to support themselves, encouraging community-led solutions and interventions.
- Working with communities to harness and develop their skills, experience, knowledge and passion targeted towards those in the community requiring the most help.
- Supporting active, healthy communities; to prevent, reduce or delay the need for more intrusive and costly public services.
- Arranging resources to create multi-agency support which can flexibly meet changing needs of communities.
- Taking an experimental approach to delivering individual local solutions and fostering ideas that can be replicated.

While many of the local government organisations already operated in this way to an extent, in recent years there has been a formalised approach to embedding it across the region, and to make it more effective – improving the consistency of messaging, formalising, organising and embedding the approach across the system (while trying to stay local and relevant to each region). This includes work into communications, estates and buildings, community engagement, funding and resources, technology and digital, workforce reform, strategic coherence and system governance. Although there is still work to be done – some areas have formalised the approach more than others – the overall ethos around Think Communities is hugely valuable in this region. It is an asset that should be nurtured.

Think Communities has been endorsed as an approach underpinning public service reform by the Cambridgeshire and Peterborough Public Service Board, and is endorsed in the Draft Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy.

The collective response to the coronavirus in 2020 provided a test base for the value in a Think Communities approach, and evidence that this place-based way of doing things is not only the right way, but the most effective way of supporting people. We discuss this later in this report.

RECOMMENDATION: Prioritise making local organisations - local authorities, district, city, town and parish, communities - the delivery mechanism for wellbeing strategies. Invest in them, acknowledging that investment does not always mean financial support. Encourage the use of innovative and sophisticated prevention approaches, including drawing on the vast resource of the private sector.

COMMUNITIES THAT LEAD ON WELLBEING

"Place-based interventions can be designed to improve population health and strengthen community bonds simultaneously – for example, through group-based social activities in public spaces that encourage physical activity. This can be particularly helpful in new places where the community is still becoming established, but it is also applicable elsewhere." – The King's Fund[xxi]

In our interim report we argued for a prevention model of healthcare that was localised and led by the population – a population health approach. Many groups responded by telling us about work already going on that matched this, particularly at local council level and in communities. For this reason, we have extended and focused our recommendations, to advocate a population health approach across the region, which puts the community at the heart of the prevention of illness.

When it comes to prevention activities and wellbeing, the investment has to be social investment. [You need] a strong voluntary sector and community-based sector to keep people well." - Council Leader

Through the work of the Commission we have found countless examples of small-scale approaches to mental and physical wellbeing. The small scale approaches exemplify an approach based on localism and prevention, and should be the basis for policy going forward.

DIVERSE COMMUNITIES FORUM (DCF), FENLAND

The DCF is a sustainable, multi-sector partnership that has received national recognition for making tangible differences to people's lives. Community involvement has been crucial in engaging hard-to-reach groups and delivering projects improving the quality of life for both current and future communities.

Wisbech is within the top 20% of the most deprived areas in the country, and an estimated 33% of the population are from a migrant background and undertaking unskilled work. Poor cohesion has created a variety of complex challenges, impacting the quality of life. This includes negative perceptions and resentment towards migrants, language barriers affecting access to local services, housing problems, poor educational outcomes, and health problems caused by sub-standard housing or excessive alcohol consumption.

The DCF recognised that to make long-lasting, positive impact, change needed to be made from within communities. It is formed of over 30 partners across statutory bodies, housing associations, health, community, voluntary and faith groups. They tackle issues that cannot easily be addressed by a single organisation. Since 2017 they have successfully bid for nearly £2.2million from the Controlling Migration Fund, available for local authorities facing pressures linked to recent immigration.[xxii] The work has been recognised as best practice by the Ministry of Housing, Communities and Local Government and the East of England Local Government association.

Many of the DCF activities and initatives have an implicit or explicit health focus. The 'Grow it, Cook it' project has educated over 80 families to grow their own vegetables and prepare food. They have also organised local activities such as yoga, football and basketball, which help to increase exercise and reduce social isolation. These projects are prioritised through factories and supermarkets to reach workers who may benefit most from their activities. The local footprint enables them to target populations they know will be in greater need.[xxiii] Such community based approaches strengthen people's sense of belonging; as well as contributing to population health and reducing pressure on acute statutory services.

Other examples of food health promoted by the community comes from community-led initatives such as the Cambridge Food Hub or the Community Fridges in Peterborough. The Cambridge Food Hub aims to increase the accessibility of sustainable food, supporting local producers and small business. This includes education and research, recycling, and running a distribution network, creating what it calls an innovative sustainable local food system.[xxiv] Community Fridges have been set up in locations across Peterborough by the Peterborough Environment City Trust. These aim to reduce food poverty, and to reduce foodwaste. This is in partnership with the Sainsbury's Waste Less, Save More initative, FoodCycle, Cross Keys Homes, and the City Council and Healthy Schools programme.

One way that the CPCA can support community-based approaches is through the provision of infrastructure, space and location. In cities and towns this could mean the use of high streets as vibrant community assets with retail premises complemented by community and statutory initiatives that enhance wellbeing for local people – from anti-loneliness initiatives, mental health peer group support through to social prescribing, volunteering and Neighbourhood Cares initiatives. A holistic approach to health also means thinking creatively about what a 'health space' looks like: using high street space, libraries and public spaces.

GAMLINGAY PARISH

Gamlingay is an example of a parish that pulls together its assets and resources in a way that supports the health and wellbeing of its residents, in this case entirely voluntarily, with minimal funding. They are specific to the needs of the people, designed and delivered by the community, locally run and have local impact. Examples of activities include[xxv]:

- Connect Café: a weekly café held within the refectory, to bring members of the community together; connect people with each other and address social isolation. By holding these Cafés on a Friday afternoon, there was a notable reduction in demand for GP appointments on Monday mornings.
- Community Care Matters: A community interest company that connects professional carers to families and providing them with employer support.
- Millbridge Brook Meadows Park: specifically designed to attract people to green space who might not otherwise access nature. This has been achieved by creating wheelchair-friendly access, and rest benches along a designated route.
- The creation of a skate park and development of allotments.
- A community mobile warden scheme to support older, vulnerable members of the parish. For a small fee, a warden will make a daily telephone call and a weekly visit, supporting the individual to continue living independently for as long as possible. As well as checking in to ensure they are safe, this could also include help with post or forms, appointment making, buying essentials, collecting prescriptions and signposting to other sources of help. They reassure the individual that someone is there and cares, listens to them and provides vital contact to the outset world. These schemes can be accessed indefinitely or following a period of illness or hospital discharge to help the individual get back on their feet more quickly.

It was noted by the Council representatives at Gamlingay that Parish-level innovations do not often require a great deal of funding, but instead rely on the energy of local people to start and run them. This informal voluntary work is vital to local areas, and it cannot be centrally created. Instead the conditions need to be created to foster the environment that will allow them to develop. This could be in the form of local council support.

Another example comes from St Ives. In 2019 a volunteer led-group set about making it a 'CALMtown: one that helps to reduce loneliness and mental ill-health through building community connections, creating a culture that it is good to talk.

PRIMARY CARE NETWORKS AND SOCIAL PRESCRIBING

Launched in July 2019 with the introduction of a new National General Medical Services contract, Primary Care Networks (PCNs) are GP practices working together to cover communities of 30-50,000. The aim is for these networks to be connected to the neighbourhood and services around them (an 'Integrated Neighbourhood' – the structure of which we discuss later in this report on P46) and the ability to connect health services with public services in a person-centred approach. The success of the PCN relies in large part on its ability to embed itself in the community. We have in the region several PCNs that are already doing this well. Granta Medical Practice is the best developed, and arguably one of the most developed in the country.

Granta's Integrated Neighbourhood was formalised in January 2019, but many of its community activities were in place before then. Their 'Through the Door' project was set up in April 2018 to fund a non-medical "link worker", based at the surgery, to whom GPs and other health professionals could refer patients. The link worker works with patients to identify how their needs could be addressed within the community, and where gaps in provision could be filled by setting up walking groups, lunch clubs, and so on. Granta is also being supported by the local council to establish a 'Wellbeing Hub': partners from the NHS, local council, the voluntary and community sector and patients are using a shared working space to develop a multi-disciplinary approach to ensure patients get the right support from the appropriate people. This has helped introduce NHS colleagues to support available that they might not previously have been aware of. Granta also has a Wound Care Pathway, aiming to deliver leg ulcer care more effectively across the community, and a Neurology Outpatients project, encouraging collaboration between primary and secondary care and implementing a new approach to the delivery of outpatient services.

Peterborough's Thistlemore Medical Centre is another well-developed PCN. This is a GP practice in a dedicated, purpose-built location in one of the region's most deprived communities, covering a population of 50,000 that faces high levels of poverty, obesity and smoking rates. Thistlemore is currently developing a site for Cambridgeshire and Peterborough Foundation Trust (CPFT) and all of the council community services, taking a place-based approach. Because Thistlemore brings council services within the same building, patients entering the surgery can use it as a 'one stop' visit, helping to de-escalate referrals.

ResPublica, in its report (2019) commissioned by CPCA to identify opportunities that might be achieved by devolution, recommended that PCNs be the main vehicle for delivering health and social care across the region in a devolved approach.[xxvi] While we acknowledge the role that PCNs have in the health system, we do not feel they are best placed to be the main driver for health. Many are still in their infancy, and would be catching up with the progress already made in public services more generally – in neighbourhood and community led approaches. This is expanded further on page 45. Nevertheless, PCNs have a vital role to play and there is much to learn from the experience of those PCNs that have made the most impact. They have developed strong relationships with local authorities and the voluntary sector, and pioneered social prescribing.

SOCIAL PRESCRIBING

One of the key aspects of the PCN is Social Prescribing. This is a general term for GPs being able to refer or "prescribe" social activities in local neighbourhoods for patients' mental and physical wellbeing. Social prescribing is growing in importance. It is particularly helpful for dealing with aspects of a patients condition that are contributing to their illness but cannot be improved by a conventional medical prescription. Lonelines is a good example. Social prescribing can provide as stimulus for increased volunteering and community problem solving. Where local resources are put behind the social prescriptions, it can lead to a virtuous circle of involved patients and effective community organisations. Examples of effective social prescribing in this region and others include for example the building of a sensory garden within a hospital ground, to which the local GP can refer patients to be part of the volunteer team that maintain the garden. Volunteers have spoken about the value of developing friendships, having a regular commitment, attending some social activities and the benefit of working in a garden in the fresh air.

The value of social prescribing comes both from the presence of the prescriber (the link worker) within the PCN who is able to identify need, and the "prescription" itself: it relies on there being voluntary schemes in place. There is a huge amount of voluntary action and goodwill in this region, but it is not always well joined-up, particularly in comparison to other regions. Many individuals we spoke to noted that at times the geography, connectivity, culture and social landscape in parts of this region can be a barrier to the strength of the community and voluntary sector.

VOLUNTARY SECTOR EMBEDDED WITHIN THE SYSTEM

To fully realise the community assets in the region for health and care, the infrastructure must include the third and voluntary sector in a formal way, as well as informal. This sector is a vital partner. As well as providing care, it is also invaluable at providing advocacy and a voice for vulnerable people, medical support and research, assisting those in poverty, support families in need, provide mental health support, guidance and education, and helping to address social and digital deprivation.

A truly functioning system must regard the voluntary and community sector as an equal partner, rather than outsiders in a statutory-based system. One example of this working well is the Rough Sleepers Task and Targeting group in Peterborough. It brings together public services and voluntary organisations that support rough sleepers and the homeless, including police, probation, local hostels, night shelter, the drugs and alcohol unit, GPs and the voluntary sector: a local church-based charity that provides services to homeless people in Peterborough. As a member of the group told us, this approach works so effectively because it encourages collaboration, shared decision-making and open communication between bodies that provide care or support to individuals. They build plans together and share responsibility and risk. This means much more effective outcomes for the people they are there to help, and better working relationships between the organisations.

If local health and social care systems are to work well they need the help of the third sector. They can better reach individuals and groups living in vulnerable or marginalised circumstances, to support the innovation of new social enterprises, and to benefit from the smallest community groups, which are often the glue keeping our communities together. At its best, the sector not only delivers to individuals, but also draws upon whole communities, both for volunteering and social action. It is uniquely able to

address service-resistant problems like loneliness and stigma, and for draw on the expertise of lived experience in designing more effective, sustainable services and systems.

Voluntary and community groups are now delivering large-scale service contracts for some of the most vulnerable people in public service systems. This is hugely valuable, as these organisations can remain rooted in their communities and continue to deliver added "social value" through recruiting people with lived experience or from overlooked communities as volunteers and paid staff, for instance.

Many third sector organisations lack confidence, some lack hope, and most are torn between following missions born from their communities and meeting the demands of contracts and grants which were defined elsewhere and which in many cases are becoming shorter term, more narrowly focused and more medicalised. This is in part a result of austerity.

Funding is, as ever, a major problem. The coronavirus pandemic has had a devastating impact on charity finances, with a huge fall in income predicted throughout 2020 as a result of the loss of giving, cancellation of fundraising events, closure of shops, economic downturn, balanced against an increase in need, particularly for charities such as Age UK or Carers UK, which responded to needs created by the pandemic and lockdown measures.

The The National Council for Voluntary Organisations (NCVO) estimated that the sector could lose a collective £4 billion in income through April-June 2020.[xxvii] In March 2020 the Institute of Fundraising estimated that Covid impacts would result in an estimated 43% of charities facing an increase in demand and 52% needing to reduce services thanks to a 48% reduction in voluntary income.[xxviii] By August 2020, health was one of the worst hit in terms of redundancies in the charities sector, with hundreds of people being made redundant at key charities such as Age UK, Cancer Research UK and British Heart Foundation.

One of the challenges of utilising and relying on volunteer and community assets is that it can reproduce existing hierarchies and inequalities. Areas that have strong community assets in the form of more people with time and resources to volunteer are also those likely to be more affluent, while areas that face greater challenges may also have fewer resources in the community. This is not to say they are weaker, but that they are likely to benefit from additional resources to support new initiatives. It is important that the allocation of voluntary resources does not turn into in a postcode lottery. As in our recommendations above, the CPCA needs to consider health and social inequalities.

As one of our interviewees pointed out, the additional funds from the government for social prescribing are allocated to the role of the prescriber or "link worker" who is there to "prescribe", but not to the resources being prescribed. One of the advantages to the Neighbourhood Cares approach, for example, is that the nurses and staff are involved both in "prescribing" or recommending initiatives and also in setting up and facilitating initiatives.

AN EFFECTIVE MIXED ECONOMY OF THIRD, PRIVATE AND PUBLIC SECTOR

To support a local-led, place-based approach, the region must also help create and use more creative and innovative models of support that work better with the local voluntary and community sector. This will enable the region to develop a mixed economy of public sector, third sector (voluntary and community) and private sector, each held to account for the quality of their delivery, their long-term value for money, and client responsiveness.

Voluntary and community resources are now more important than ever and many statutory bodies are embedding the sector into their planning and resource management. Money is not the only resource available, and the sector has proved itself time and again to be able to achieve incredible outcomes with fewer resources.

The immediate challenge is to engage our most effective, confident and community-rooted organisations as partners into coming up with new models of care. These opportunities would be served better by the opportunity provided by the devolution of health budgets. This in turn will support integration, because effective and well-networked voluntary and community organisations can join up responses that have previously been fractured and can help build relationships between public services and communities.

There is also need for a more considered range of funding approaches in every area. This should include use of co-designed, transparent grants programmes as well as personal health budgets, which can allow individuals and small groups to take real responsibility for shaping their care, with consistently better outcomes for people with long-term conditions and their family carers.

PUBLIC PROCUREMENT AND SOCIAL VALUE

There is broad concern about the quality and transparency of business relationships within the procurement process and supply chain, particularly with regards to public procurement in the UK. One way to solve this problem is to use leading-edge assessment tools to ensure that the mixed economy is always a responsible one. In place of crude outsourcing, there would be a discriminate delegation of tasks to social enterprises, mutuals, charities and private sector organisations that can pass a so-called Trust Test[xxix] that assesses their culture and alignment of purpose and values with public objectives.

The Trust Test was developed by Tomorrow's Company as part of a 2013 project entitled Tomorrow's Business Forms.[xxx] The idea is that as part of the procurement process an organisation would be screened for aspects of its culture and character, alongside the normal details of price and performance. A standard set of requirements that organisations can meet to demonstrate trustworthiness to other organisations was then developed by a series of stakeholder workshops undertaken by the British Standards Institution (BSI). BS 95009[xxxi] is a tool to simplify and strengthen public sector procurement processes – written very much with SMEs[xxxii] in mind (99% of UK charities are SMEs). It is the first generic, non-sector-specific standard for procurement in the UK public sector. It specifies how an organisation can demonstrate that it is: a) suitable as an external provider of products and services to the public sector, and b) able to reliably deliver products and services meeting the requirements of the contracting authority. The requirements apply to any organisation, regardless of type, size or the nature of its activities. The criteria set out can be used both by organisations that are contracting out provision of products and services to external providers, or that are acting as external providers.

Historically, UK public sector procurement struggles with a poor reputation: there's a perception that the processes involved could be fairer, more transparent and more accessible to smaller or newer organizations. This standard was written to tackle those issues. It provides criteria and guidance that enable potential suppliers to demonstrate their generic trustworthiness, transparency and ethical practice. At the same time, procuring bodies can use the standard to assess bidders more readily and accurately. Overall, the standard should simplify the process, reduce bureaucracy, ensure due diligence, and provide assurance that fairness prevails in the awarding of contracts.

More specifically to health and social care provision, here are two examples of ways in which the procurement process could be more innovative in a devolved setting. 1) Social value should become a fundamental part of health and care commissioning, service provision and regulation. CQC should review its Key Lines of Enquiry and ratings characteristics across all sectors to include the value of personalisation, social action and the use of volunteers, based on the evidence of their efficacy in achieving improved quality of care. 2) NHS England, working with key partners such as the Department of Health and NICE, should support good practice guidance on social prescribing which includes advice on different models and recognition that prescriptions should be appropriately and sustainably funded. NHS England should promote this guidance, provide implementation support to health commissioners and evaluate uptake and impact on outcomes, including for those people experiencing inequalities.

RECOMMENDATION: the CPCA should endorse and where possible enact innovative approaches to procurement to ensure these relationships are built well, such as the Trust Test to ensure appropriate outsourcing.

THE IMPACT OF THE CORONAVIRUS PANDEMIC

"There has been an overwhelming response from community volunteers, with more than 2000 people signing up for the Cambridgeshire County Council volunteer scheme, with almost no push from us. We [Cambridgeshire County Council] are now looking at how the existing Voluntary and Community Sector infrastructure can be used to mobilise this. At present, there are far more volunteers than work they can do, so we are looking into how we can keep this momentum going, keep these volunteers and community groups active even beyond the Covid crisis, and link them into the existing voluntary sector where they can be helpful.

This is as much about messaging as structure. Asking community members to volunteer in other ways. Saying things like "You might not be needed at the food bank but you can be a really useful member of your neighbourhood and community just by being a good neighbour, joining neighbourhood watch". The members of the community can do a huge amount for each other and could be a great resource for the VCS [voluntary & community sector] going forward."
- Council Team member

We have never had a better opportunity to put more resources into the community and to help the community function differently than we have seen during the coronavirus pandemic. Across the country and across the region communities have rallied to look after each other at a truly local level. The formation of mutual aid groups has given local groups a formalised structure, at times as small as street or parish level. This has happened more organically than the more traditional volunteering structure that the voluntary and community sector utilises; it has made everyone into a volunteer. One mutual aid group leader in the region noted that the pandemic has demonstrated to them that one of the barriers to communities helping each other more is not knowing what other people around you need, or having the communication channels in place to find out. With the potential threat of Covid and the lockdown measures it is made obvious what people need: everyone is going through the same things. Groups set up clear channels of communication with each other, using WhatsApp groups, email groups, and some building more formal channels of requests for help.[xxxiii] This process may bring more of this to light, to help the community understand each other's needs and set them up for helping each other in the future.

The voluntary and community sector itself has made clear in the response to the pandemic that it is an invaluable resource, and that it can adapt to changes quickly to meet needs with informal and community-based health service provision and support. It has worked effectively with the NHS and public service providers. It has also – as all parts of the system have done – made quick changes in how it delivers services, moving some services online, and going through digital transformation. These mobilisations need to continue to be part of health care and must be included in future plans. The groundswell of goodwill and energy in informal and community-based provision needs to be supported if it is to continue, and better connected with public services, PCNs and social prescribing.

The pandemic also demonstrates how valuable it is to have localised responses and assets, and where a centralised approach from central government or NHS England at times hindered local and community work.

At the beginning of the pandemic the councils and local communities had a huge number of people volunteering: in the formal council scheme at county and local authority level, with voluntary schemes at smaller community level, and in grass roots organisations in the form of mutual aid groups. Central government then announced a national volunteer scheme for the NHS, for which a record 750,000 people signed up. This then came under criticism for its ability to deliver: there were delays in deploying those volunteers, they were not used effectively, and there was little or no connection made between those volunteers and the localised approaches already happening. Within Cambridgeshire and Peterborough at the time work was already underway to set up systems for the local Health and NHS partners to use the volunteers who had signed up at the council community hub. This meant there being two databases of volunteers, and the council and health teams needing to work out what this meant for the schemes, collaborate and share information about how this would actually happen, and when. This duplication of action creates a time and energy burden that could have been avoided with a bottom-up approach to volunteering – a policy put in place by central government that could have been better implemented locally.[xxxiv]

At the beginning of the pandemic all of the local councils collaborated to put a plan in place for how they could support the local communities through lockdown, including volunteer co-ordination and the development of a hardship fund. In the second week of lockdown measures, central government brought in a national mandate for the County Council to create a Hub, with clear instruction on what

that should entail. A member of the Think Communities team told the commission that "'From a Think Communities Perspective, that was probably our most testing few days, because we had to work in a way that really goes against how we've been trying to work the last two years: we had a mandate from the top and we just had to get on with it and we didn't have time to engage with district councils on how we did it." They noted that work since has had to focus on repairing relationships and acknowledging the need to work collaboratively going forward. In particular, the subsequent approach prioritised the district councils as being the best to deliver localised approaches that are most relevant to the area.

This pattern – of centralised approaches being superseded by more efficient localised approaches was also seen in the approach to PPE procurement and to the track and trace systems, where centralised approaches failed to materialise and local approaches have taken over. By July 2020 just 72% of people who tested positive for Covid were contacted by NHS Test and Trace,[xxxv] with many local government council areas putting their own systems together. Even more recently, as this commission was finalising this report, we have seen examples of efficient local-lockdowns being administered at the decision of the local government leaders, rather than central government, and a confused approach from central government. There is an argument for saying that the response to the coronavirus pandemic has been successful despite, rather than because of, central interventions.

"Health professionals on the ground in doctors' surgeries, hospitals and care homes have been offering up local solutions on procedures and procurement, and on testing and the transfer of patients, that have been constantly ignored or overruled by central institutions – the Department of Health and Social Care (DHSC), NHS England and Public Health England – creating problems for the future."
- Andrew Lansley, 2020.

UNDERSTANDING NEEDS AT A LOCAL LEVEL

Helping marginalised people to have their voices heard is indisputably a key part of voluntary sector activity. Many organisations are born in the gaps and failures in statutory services, for example where a particular service cannot reach a particular group. The voluntary and community sector plays a vital role in amplifying those voices which are seldom heard, helping them to engage with the health and care system. All systems need the voluntary and community sector included in their decision-making structures. They can bring into the system the voices decision-makers most need to hear – but those voices must be listened to and acted upon, even (and especially) when they are not saying what decision makers might most like to hear. NHS commissioners and local authorities should work with the voluntary sector to enable all groups in society, especially those experiencing health inequalities, to have a say in how services can achieve better health and care outcomes for all citizens.

RECOMMENDATIONS:

- The CPCA should embed and endorse a localised, mixed economy approach to care and wellbeing in the community – using public, private and third sector.
- The CPCA should prioritise making local organisations - local authorities, district, city, town and parish, communities - the delivery mechanism for wellbeing strategies. Invest in them, acknowledging that investment does not always mean financial support. Encourage the use of innovative and sophisticated prevention approaches, including drawing on the vast resource of the private sector.
- NHS and central government (the Department of Health and Social Care) should adopt a less centralised approach. This should concentrate on national policy frameworks to empower and liberate local government to deliver in their own ways.

A Whole Region: health in all policies

This Midwestern city had high smoking rates and low activity levels, and they climbed out of a health and economic crisis with projected lifespans increased by nearly 3 years. This included 2.9 years added to lifespans within one year of participating in the Blue Zones Project. The Downtown Streetscape revitalization has increased private investment, tourism, and the tax base and $7.5 million in savings in annual health care costs for employers.
Blue Zones Project, MN[xxxvi]

Having focused in the previous two sections on the role of the individual and the role of the community, we now turn to looking at the region as a whole. In this section we focus particularly on the policy changes the CPCA could make in relation to prevention strategies, and the role that devolution might play in furthering both prevention and the integration of health and care systems.

HEALTH IN ALL POLICIES

At a high level, there are two ways that the CPCA can contribute to the health of the population through its approach. One is 'Business as usual' – using the CPCA's existing powers to contribute to healthier living in healthier places. The other is to help to bring about a form of devolution of authority for health and social care that would make possible a localised and integrated approach, with combined budgets that free all concerned at the level of individual cities, districts and neighbourhoods to focus on prevention, shorten lines of communication and respond to local need.

When we asked those across the region what the CPCA could do to support health, many responses could be summarised with the words: 'Stay out of the way and don't make things more complicated than they already are'. Given the tangle of overlapping bodies with responsibility for health and social care this is understandable. The only reason for making a devolution bid to central government is if this opens the door to genuine localisation and simplification.

In the meantime, there is a major opportunity to put health at the centre of every decision made by, or influenced by, the Combined Authority.

A WHOLE HEALTH APPROACH

'Our health and wellbeing is shaped by much more than just health care. The places we live in affect our health in countless ways, including through the way a neighbourhood is designed, access to green spaces and the provision of good public transport. The social environment plays a key role too: strong social relationships or, conversely, stressful living conditions, can impact on our mental and physical health, and there is evidence that good urban design and planning can help to encourage positive interactions and improve health' - King's Fund, Creating Healthy Places[vii]

Health needs to be considered in all policy decisions from the outset. The Mayor and the Combined Authority currently have responsibility for a wide range of policy areas which include regional economic growth, housing; transport and connectivity; skills; public service delivery; tackling deprivation, and improving quality of life. Establishing this Commission already signals the Mayor and Combined Authority's commitment to the importance of health and social care to the economy and to the community.

Councils and public bodies influence the decisions each of us make. If there are no local fields on which children can play football, their wellbeing, and quite possibly their future lifestyle, is adversely affected. It is hard to make the right food choices if junk food is on our doorstep and healthy food is too expensive or inaccessible. If a city has more cycle lanes and less polluted air, then more of its citizens will make healthy transport choices. Health needs to be at the centre of infrastructure decisions.

The NHS 'Healthy New Town' initiatives and the building of 'Blue Zones' are two programmes that put health at the centre of decisions regarding public infrastructure, transport and town planning, and deliver effective approaches to population health and integrated care.

BLUE ZONES

Blue Zones are an example of how public health can be promoted by changing the area and community to nudge residents into healthy living.

In certain places around the world, longevity – and healthy lifespan - is shored up simply by the way people live their lives. Terming these places "Blue Zones", the researchers that discovered this longevity developed an idea about the promotion of public health. Rather than focusing on changing individual behaviour, the area and/or community must be changed to "nudge" its residents into exercising, eating well, and generally living more healthily and happily.

This kind of change involves a number of different factors, but there are two fundamental ones: close, community-based social structures, and access to the right diet – i.e. living in a place where healthier foods are the most accessible and affordable. These factors can in turn support lifestyles that encourage people to be 'nudged' into movement, in particular through the kinds of work they do and the ways they get around.

Creating a Blue Zone demands certain things of the built environment and those that manage it. Roads, transportation and public spaces must be accessible. Municipal entities and businesses should help promote activity and discourage poor eating habits, including in restaurants, schools, workplaces and shopping areas. Social networks and groups that promote and support healthy habits should be fostered and supported. The design of new homes should encourage healthier eating and more movement. Blue Zone communities must help their residents focus on their "inner selves", encouraging people to avoid stress and instead enable their sense of purpose, improving mental health. This too can be encouraged and supported across workplaces, schools and the voluntary sector.

These are examples of the numerous interventions that could be adopted by the CPCA; indeed there are areas that are already in place that just need to be expanded.

Primary Care Networks, Neighbourhood Cares programmes and other similar community health-based approaches require premises, and many are restricted by a lack of space. One respondent to this commission noted that some of the PCNs in this region have not been established in an appropriate building yet. Including health partners in planning discussions could help these organisations to develop and flourish. Healthwatch Cambridgeshire and Peterborough has excellent understanding of where a lack of access is preventing patients accessing services, and they too should be involved in planning, to ensure patient and peoples' voices are heard. High street premises could be made available for health hubs, community meeting points and volunteer co-ordination centres, giving physical shape to resilient communities of the future.

TRANSPORT

The Combined Authority Local Transport Plan includes health and wellbeing for both existing and new residents as a key policy element, aiming to provide 'healthy streets' and high-quality public realm that puts people first and promotes active lifestyles. It also rightly states that travel is a key resource for helping people with opportunities to employment, and therefore a driver for both economic growth and reduction of social inequality and disadvantage. Another challenge for some regions is access to healthcare, which could be addressed by a health-inclusive approach to transport design. One of our interviewees noted this explicitly, suggesting that the transport strategy had been focused on ensuring people could travel to work, perhaps at the detriment of ensuring people could travel to healthcare providers. The plan should be extended to ensure transport planning that makes travel to GP surgeries and hospitals easier is favoured when future transport routes are planned. This is even more vital given the shift that has occurred as a result of the pandemic, with vast numbers of workers now working from home, but with even greater need to be able to travel to health centres.

The city of Cambridge and South Cambridgeshire both have relatively good access to GPs, while areas near Fenland, in East Cambs and to the west of Huntingdonshire have poorer access. The connection between transport and health is often described as it is in the ResPublica report: "transport and connectivity should be considered within the high-level commissioning and governance mechanisms for health and social care". We conclude, conversely, that health needs to be a core purpose and decision making framework within the high-level mechanisms in the Transport Plan. These are all approaches within the current gift of the CPCA. The Combined Authority's Local Transport Plan policies for 'Creating Healthy Thriving Communities' need to be implemented throughout, and the implementation monitored.

HEALTHY NEW TOWNS

THE 10 PRINCIPLES OF HEALTHY NEW TOWNS - NHS ENGLAND

1. PLAN AHEAD COLLECTIVELY
2. ASSESS LOCAL HEALTH AND CARE NEEDS AND ASSETS
3. CONNECT, INVOLVE AND EMPOWER PEOPLE AND COMMUNITIES
4. CREATE COMPACT NEIGHBOURHOODS
5. MAXIMISE ACTIVE TRAVEL
6. INSPIRE AND ENABLE HEALTHY EATING
7. FOSTER HEALTH IN HOMES AND BUILDINGS
8. ENABLE HEALTHY PLAY AND LEISURE
9. DEVELOP HEALTH SERVICES THAT HELP PEOPLE STAY WELL
10. CREATE INTEGRATED HEALTH AND WELL-BEING CENTRES

"NHS England's Healthy New Towns programme has shown how large-scale housing developments and regeneration projects can be used as an opportunity to test and deliver innovative approaches to population health and integrated care, aided by a strong focus on community development. Many of the lessons from the programme are also relevant to existing places." [xxxviii]

The Healthy New Towns programme, launched in 2015 by NHS England, was put in place to explore how the development of new places could provide an opportunity to create healthier and connected communities with integrated and high-quality health services.[xxxix] This initiative is an experiment, and a demonstration of a "whole systems" approach to creating healthier places. This means giving equal weight to all the players in this field: councils; housing developers, housing associations and built environment professionals; the NHS; and those working in the voluntary, community and social enterprise sectors.

The demonstrator sites were supported to create local programme teams and build partnerships, governance structures, delivery plans and interventions to drive forward their healthy place-making. The aim was to address the following objectives:

- Planning and designing a healthier built environment.
- Enabling strong, connected communities.
- Creating new ways of providing integrated health and care services.

It is notable that two out of three of these are also key aspects of Blue Zones.

In Northstowe, Cambridgeshire has one of only ten pioneering Healthy New Towns. This is a vital asset – it offers the chance to learn how a truly integrated approach to health and development can be achieved within this region. Northstowe is a 10,000-home development on the former RAF Oakington base and surrounding land. Northstowe has used NHS England investment to understand how the built environment can contribute to improved health, how residents can be galvanized to support their own wellbeing, and how to support a new model of care with an emphasis on prevention, creating a community in which people can age well. This includes partnerships across local authorities, NHS, the Clinical Commissioning Group, Homes England and academics and researchers from the Cambridge Institute of Public Health and the Centre for Diet and Activity Research (CEDAR) at the University of Cambridge.

To establish the requirement for housing to meet the needs of older people, South Cambridgeshire District Council, in collaboration with Cambridge City Council and Cambridgeshire County Council commissioned Sheffield Hallam University to conduct an in-depth assessment of the future housing, care and support needs of Greater Cambridge.[xl] They have also devised two new tools: the Housing for Older People Supply Recommendation (HOPSR) and the Extra Care Demand Assessment (ECDA)[xli] to help local authorities across England assess the need for older people's housing in their areas. These tools are designed to ensure people are living in age-appropriate accommodation and that they can age well without leaving their community, and are used by a number of councils across England. These in-depth, academically rigorous assessment frameworks are a significant local resource, that gives a clear picture of what is needed to future-proof housing provision in the region.

The district council for Northstowe also set out to develop a scheme for those aged 55+ at social affordable rent, and has identified another new priority: Healthy Living Youth and Play. This has seen the provision of structured and unstructured play areas accessible to all residents, which provide shading and rest benches for young and old. Along with contributing to physical activity among young people, these areas are catalysts for community cohesion.

Several large housing developers in this region have already started to build on this work – adopting the ten national Healthy New Town planning principles ("Putting Health into Place"). The councils are also planning to develop a toolkit to implement the Healthy New Town principles. We believe this could be more ambitious; principles that underpin Healthy New Towns could inform every planning and policy decision made by every local authority in the region. For example, a focus on housing should also include an acknowledgement of the value of community focussed, multigenerational housing.

The government's proposed new planning legislation should be carefully reviewed in this light, and we would recommend that CPCA is proactive in:

- Setting out out a clear policy on the encouragement of the provision of multi generational housing that puts health at the heart of its approach to housing developments.
- Securing its continuing ability under new legislation to insist that, in all new housing developments, developers are required to follow its guidelines on the provision of multi generational housing.

Another example within the region where a similar 'health first' approach has been adopted is Wintringham, St Neots[xlii] – a development "with wellbeing at its core". This represents a more commercial approach to the same issue: a housing development that prioritises the wellbeing of the people. This was made possible through a collaboration between Urban&Civic and the Nuffield Trusts.

NHS England's Healthy New Towns programme has shown how large-scale housing developments and regeneration projects are an opportunity to test and deliver innovative approaches to population health and integrated care. Principles for Healthy New Towns and a toolkit for their implementation are currently being drafted; we believe more can be done. Not just adopting principles but fundamentally changing the way we build in this region by putting health at the centre. Put simply, given we have a Healthy New Town in our region, we can be more ambitious with what we learn and how we change the way we do things. The Combined Authority should identify other test sites across the region where the Healthy Towns principles can be adopted and learning from experience in these other areas.

RECOMMENDATIONS:

- Make health a strategic measure and consideration in all aspects of the Combined Authority's strategy, with particular focus on: long term investment in prevention and building infrastructure that enables health and social care to be more integrated and community based. Use learnings from the Healthy New Towns and Blue Zones.
- Commit to developing more Healthy New Towns, and adopting principles of HNT for development in existing places. This should include health partners in planning discussions.
- The Combined Authority's Local Transport Plan policies for 'Creating Healthy Thriving Communities' need to be implemented throughout, and the implementation monitored.
- The CPCA should be briefed regularly on the relevant indicators identified by the local Health and Wellbeing Board to inform all policies that can have an impact on the health of individuals and the resilience of communities. The design of any future decision-making structures should ensure that these indicators are agreed and reviewed regularly.

A TRULY INTEGRATED HEALTH AND CARE SYSTEM

It is clear to anyone who has experience of it, and even to those who are involved in its delivery, that health and social care in the region is complex. Integrating health and social care in such a way that the experience for the user is paramount, and that care is 'joined up at the point of use' is a goal outlined in almost all strategies for health, both in this region and across the UK. As we noted earlier in this report, health and care must be centred around the individual. The question therefore is how to shift the system from its current state to one that is joined up at the point of use. One aspect of this is the potential for consolidation.

POTENTIAL FOR CONSOLIDATION

Several of the people we interviewed for this work mentioned the complexity of the governance and delivery systems in place in this region and a need to consolidate them. As one person said: "Sometimes it's easier to build governance than to do something." There is acute awareness of the drag factor associated with duplication, and yet there is not the opportunity to consolidate.

As part of our work as a Commission, we made some attempt to map out the organisations involved in health and social care in the region. The result is not intended to be a definitive guide – we didn't, for instance, include any of the voluntary sector, or the organisations that are commissioned by the CCG – but even in this simplified form, it demonstrates just how much effort is duplicated across different delivery bodies and boards. In our review of who sat across these bodies we were struck by how many people are involved in multiple bodies, meetings, committees and groups, duplicating efforts and agendas. If we also factor in the resource required to support these bodies – without even accounting for the time costs of the people attending each meeting – it is clear there could be huge gains made by simplifying and consolidating. We heard this feedback and frustration in many of our interviews too, even from those who are involved or sit on the various bodies.

For example, many people mentioned the Cambridgeshire and Peterborough Health and Wellbeing board, highlighting the gap between what it could achieve and what it currently achieves. The group has huge potential to be a multi-agency group that drives the health agenda for the region, but as it stands, many felt that it is only to sign off the health and wellbeing strategy. The move to integrate it – by creating a sub-committee of the two health and wellbeing boards that are collectively responsible for the joint strategy – has duplicated membership rather than simplifying the approach. One interviewee described it as being "too managed" and not bold enough.

Another area of duplication and fragmentation is the relationship between the CCG, the STP and the Public Services Board. Although there is huge appetite among the members of these boards to work together, it does not always work well in practice – again, leading to duplication of agendas and membership. Towards the end of our consultation work, several members of these bodies noted that the coronavirus pandemic had led to relationships being greatly strengthened. They acknowledge the vital need to be a united front, not pulling against each other.

While these are two key examples, the frustration at duplication was not directed at any one particular part of the system. We heard similar comments about almost every governance body or board, and picked up on a pervasive frustration amongst most parties that the levels of complexity and governance mean there is too much talking instead of action. There is also not enough genuine collaboration between the different bodies, too much repetition of agendas, and not enough co-ordination between the various parts of the system. The mapping exercise that we underwent is a starting point for identifying where there are duplications, and overlaps, of board members and agendas.

It should also be noted that many of these bodies and boards are nationally mandated.

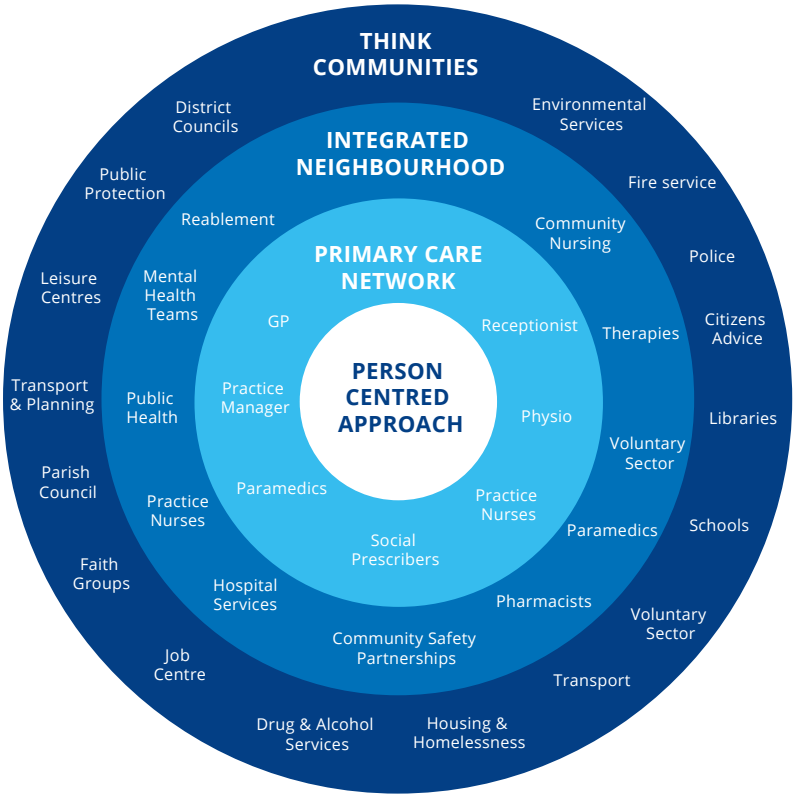
The need to integrate service delivery is well understood by people across the system, and there is huge appetite to make it happen – especially given the impact of Covid. Our overall impression is of a system that is open to change, aware of the need to integrate, and aware of the drag factor involved in duplication.

While there is still a great deal of 'tribalism' across individual systems, this is far from impossible to overcome. As the region's services change and become more integrated, we will have to explain the changes properly to people as we try and empower them to access what they need.

EXISTING INTEGRATION

People across the region acknowledge that the current system is complicated, and they are eager to see health and social care be more joined-up.

Many of those we spoke to pointed to the problems that arise where services are commissioned by two different parts of the system – health and social care – and the person needing help at the centre of it struggles to get access to the right services.



EXISTING INTEGRATION APPROACH IN THE REGION

"Examples of where it is a real problem for health and for the local authority is where you have these grey areas. So take as an example: Continuing Health Care. If a family or an adult is assessed to meet the continuing care criteria, it will be fully funded by health. But when health is financially challenged, they will be looking to try to pass some of the cost onto the local government. And at the centre of it you have a family that needs support. And the argument isn't about whether that person needs the care, it's about who is going to pay for it."
– Adult Social Services team member, County Council

There are some areas where services are already jointly commissioned between the local authority and the CCG. It is also in the terms of reference of the Health and Wellbeing Board to consider options and opportunities for the joint commissioning of health and social care services.

Over the last two years those working in health and social care and related public services have made concerted efforts to improve their collaborative working. The development of PCNs, Integrated Neighbourhoods, and the "Think Communities" approach are all strengthening the relationships between parts of the system. These three parts of the system are organisationally different, limited by their budgets, and still in their infancy. Yet despite the difficulties this inevitably presents, there is a general feeling across the initiatives that these early efforts to integrate are the beginning of something significant and beneficial. It is vital that any contribution or involvement from the CPCA be contributory to and/or supportive of these projects. Below we outline how these parts of the system are currently working, to indicate where reform could support their working going forward.

PRIMARY CARE NETWORKS

Primary Care Networks (PCNs) were formally launched in July 2019 with the introduction of a new National General Medical Services contract. PCNs are groups of GP practices working together to cover communities of 30-50,000 people and provide wider primary care services. In Cambridgeshire and Peterborough there are 21 PCNs. These are in varying degrees of development: some are very well developed while others are in their infancy.

The leading PCNs in the region – ones that were highlighted to us as exemplars – are Granta Medical Practice (24 GPs in South Cambridgeshire) and Central Thistlemoor (11 GPs in Peterborough). Granta Medical Practice has been operating under a community-led approach for a long time, and had many of the characteristics of a PCN (such as social prescribing) before it was formally launched nationally.

Local PCNs have accessed support in line with PCN development nationally, including:

- Leadership and partnerships, including: clinical backfill for staff; networking opportunities with clinicians from secondary and community care; participation in the Judge Business School Primary Care Innovation Academy.
- Population health management. This includes access to bespoke population health data packs and implementation of Eclipse and RAIDr population health management tools.
- Bespoke workshops on establishing new, joint organisational forms and shared finances.
- Guidance on recruiting key new roles e.g. Social Prescribing Link Workers.

While this support is available, many PCNs are still relatively undeveloped. In interviews for this commission we were told that some are still yet to set up premises or establish sufficient staffing to run at their full capacity. Access to services is therefore still patchy. Primary care mental health services were also brought in in recent years as part of the attempt to have more services available in the community, reducing referrals to specialist community mental health services. This can be effective, however there are still issues with people getting access to services. Healthwatch for example note that 'whilst people appreciate the chance to be listened to about their mental health issues they can be frustrated about the continued lack of access to actual treatment. These services are still not fully rolled out and are not expected to reduce fully the ongoing demand pressures on Locality Teams".[xliii]

INTEGRATED NEIGHBOURHOODS

Supporting and surrounding the PCNs are Integrated Neighbourhoods: target communities of populations of between 30,000 - 50,000. The aim of this structure is to bring all parts of the public service workforce together and put the person at the centre of the care they receive, in line with proposals set out in the NHS Long Term Plan. The ultimate goal is to dissolve the barriers between primary and community services so as to support the delivery of joined-up, holistic care that keeps local people well and out of hospital. Representatives from unitary councils form part of the local Integrated Neighbourhood boards. The intention is to change the conversation with patients and local people away from "what can we do for you?" to "what matters to you?"

NORTH AND SOUTH ALLIANCES

In August 2018, two "Alliances" of health and care organisations were established in the north and south of the region. Membership includes senior representatives from health and care organisations (primary care, community services, mental health, social care, acute trusts, voluntary services, local councils, and the CCG). The alliances are set up to implement the PCN strategy and to help develop Integrated Neighbourhoods. The vision of the alliances is to bring providers together to address the triple aims described in the Five Year Forward View - improving quality of care for patients and service users, outcomes for the local population, and value for the taxpayer.

The North Alliance serves around 568,000 citizens and covers twelve PCNs in Greater Peterborough, Huntingdonshire and Fenland; the South Alliance serves a population of around 416,000 and nine PCNs, and the footprint broadly follows the flow of citizens into Cambridgeshire University Hospital services across Cambridge City, East and South Cambridgeshire.

Integrated Neighbourhoods provide proactive and integrated care to communities of 30,000 - 50,000. They aim to keep local people well and out of hospital. Integrated Neighbourhoods build on the base of primary care networks, bring all parts of the workforce together and put the people at the centre of the care they receive. The cornerstone of each integrated Neighbourhood is a Primary Care Network.

Integrated Neighbourhoods working in a specific community around primary care and their registered population

- Size and shape will vary, but share common characteristics.

Delivery is multidisciplinary, but there will be differences in how services and functions are organised at integrated Neighbourhood level.

Additional specialties at larger scale feeding in as needed, Including:

- Specialist Nurses: Parkinson's, Diabetes, Continence Respiratory
- Dietetics
- Continuing Care
- Complex Pathways
- Wider public services - Fire, Police, Housing
- Enhanced Recovery and Support at home
- Re-ablement at home Community beds and Diagnostics
- Drug and alcohol services

The registered GP Surgery is the 'cradle to grave' care co-ordinator. All partners work as one team to provide wrap-around and specialist care with patients in the centre. Working in this way:

Focuses on what matters to the person.

Delivers more care to home, keeping people out of hospital.

Supports people to remain independent in their own homes for as long as possible.

Provides consistent and quality healthcare across the system.

The alliances have provided support for the development of PCNs in a number of ways, including funding for a workshop to bring together staff and patients to agree a local vision and priorities, tools, learning and analytics, and a dedicated project manager. There is also a PCN innovation fund, to which the PCNs can bid for seed funding to enable development of their integrated neighbourhood models. All PCNs across Cambridgeshire and Peterborough are implementing Innovation Fund projects with support from alliance teams.[xliv] This approach will be used to scale the implementation of Integrated Neighbourhoods across Cambridgeshire and Peterborough over the next five years. The aim was to implement eight Integrated Neighbourhoods in 2019/20 and a further 13 in 2020/21. The aim is to have all integrated neighbourhoods established by April 2022. Although ambitious, the establishment of the integrated neighbourhoods and the support by alliances will have been greatly impacted by the coronavirus epidemic.

SOCIAL CARE

On his first speech as Prime Minister, Boris Johnson committed to ending the crisis in social care. The coronavirus crisis brought into sharp relief the consequences for patients of focusing on relieving pressure on acute systems and emptying hospital beds without considering the impact on social care. From the PM downwards, everyone is recognising that there is a 'crisis' in social care, and we cannot carry on as we are. This was clear in our recommendations even before the pandemic, but it is now even clearer that this be used as an opportunity for this region to act as a test bed for reform on a major scale.

There is continuing extreme financial pressure on councils that deliver social care. A recent (June 2020) survey by ADASS, the Association of Directors of Adult Social Services, concluded that: "Directors see that coronavirus has made extremely fragile care markets even more susceptible to market failure at the detriment to those people accessing care and support services". While these trends were in place even before the pandemic – with decreases in the number of providers of care – there is a significant worry about the financial sustainability of providers since the pandemic crisis. From the point of view of the individual, care home fees have been rising at above-inflationary rates for several years. In 2019 they rose by 5% nationally and by 6% in Cambridgeshire in 2018. The East of England has the fifth most expensive residential care and the most expensive nursing care in the country. In 2019 nursing care was an average of £1024 per week, compared with the UK average of £880.[xlv]

We also note from our engagement with care leaders since the beginning of the pandemic that there are many cases where a localised approach has been beneficial and problems have arisen with national, centralised approaches. The clearest of this is in the access to PPE and to Covid tests. One example is in the support offered by the Cambridge Clinical Laboratories (CCL); it is part of a network of labs that have been asked by the Department of Health and Social Care in June 2020 to provide coronavirus tests. They focused on care homes, seeing them as a vital front line against Covid and offering weekly tests to staff and residents. However, they require a healthcare professional to take the test swabs.[xlvi] This makes setting up the tests more complicated for the majority of care homes, who do not have a healthcare professional in place. This is a simple example of what happens when well-meaning policy and innovation fails to deliver its outcome, by being centrally administered without enough consideration of the practicalities on the ground.

There are pockets of potential for innovation and change. We have already noted the pilot of Neighbourhood Cares approach which we discuss at length in the final section of this report (see page 47). Attempts and enthusiasm for doing things differently are all over the region. The recently-formed Cambridgeshire Care Providers Alliance[xlvii] has been supporting care providers (and helping them to collaborate and support each other) throughout the coronavirus crisis. It will provide a forum for care providers to share best practice and experiences. The need for support for the care sector and for its reform has never been clearer.

Although much of the reform will require major governance changes and a devolution of health and social care, there are some changes to social care that are within the gift of the CPCA as it stands. One area in particular is the skills agenda. We discuss this later in this report (see page 50), but it is important to acknowledge that the steps the CPCA has already taken to become a leader in the skills agenda and particularly the focus within Peterborough and at the new University make this step an easy one.

INTEGRATION AFTER THE PANDEMIC

In the latter end of our work as a Commission we spoke to several council and health leaders about the partnerships that had accelerated as a result of the pandemic, how the existing integration had fared and how public services had responded to the crisis. As we report on later in this report, the pandemic response required building of relationships to be fast tracked. We observe that it is vital for this integration to continue now that the initial threat has changed. One local government leader told us that as a result of the coronavirus response, "Our relationship with the NHS and CCG is better than it has ever been."

We should treat the experience of the coronavirus pandemic as an opportunity to identify the parts of the system that are working well and the parts that are more complicated. This is the time for some honest conversations about what the current system is achieving or not achieving.

A DEVOLUTION BID

"If we were to sit the public down and explain to them how tribal Health and Local Government are, they wouldn't believe us." – CCG board member

"It's not about asking for a blank cheque. It's about asking for the power to spend the money in the way that is most appropriate to us". – local council executive

"We have the greatest need to drive down costs and to save money. This gives us a reason for doing it, a real need for change on a major scale." – local council leader

As we have already stated throughout this report, our impression of this region is of people and organisations that are open to change, keenly aware of the need to integrate, and of the drag factor associated with duplication. The response to the coronavirus crisis has shown what can be done: traditional boundaries have disappeared and the focus has been on working together towards a common objective. The leaders involved in that collaboration want to find ways of consolidating and not abandoning this progress. Yet structures get in the way and the pace of change gets slowed. Somehow a way has to be found to create a combined budget at the local level.

The framing of the Cambridgeshire and Peterborough devolution settlement allows for dialogue with the Government on the devolution of health and social care funding. Devolution could open the door to collaboration across the region in a programme that enhances the health of its population and becomes an exemplar for a totally new way of approaching health – with substantial impacts in the short, medium and long term.

One of this Commission's tasks was to explore the potential of a devolved approach to health and social care in this region; that is, whether the Combined Authority should seek to establish devolution of health and social care. The Cambridgeshire and Peterborough devolution deal as it stands anticipated meaningful dialogue with the government of the devolution of health and social care funding. It stated that there was appetite to build on the current foundations and make progress on health and social care integration, to improve local services, and build resilience for future generations.

Since 2017, Cambridgeshire and Peterborough has had devolved powers relating to transport, planning, skills, housing and infrastructure. As was written into the devolution deal:

"To deliver this shared vision, partnerships between local authorities, the CCG, service providers and other local partners will need to be strengthened significantly. Therefore, these parties will work together, with support from Government, NHS England and other national partners as appropriate, to support local authorities through their Sustainability and Transformation Planning process to set out plans for moving progressively towards integration of health and social care, bringing together local health and social care resources to improve outcomes for residents and reduce pressure on Accident and Emergency and avoidable hospital admissions" [xlviii]

Referencing this, the final report[xlix] of the Cambridgeshire and Peterborough Independent Economic Review (CPIER) also made a case for devolution as the best route to achieving systems change in the area, stating that "it seems unlikely that the health issues considered by the Commission can be tackled effectively within the existing institutional framework of health and social care". The CPIER report went on to recommend that work should begin at the earliest opportunity to develop an approach to local health and social care devolution.

In a report prepared for the Combined Authority in 2019, ResPublica also outlined opportunities that devolution could open up. In its own words, it:

"...makes a case for an integrated, local and more sustainable model for health and social care provision. A whole-system, place-based approach. One that can more effectively respond to the needs of the population by re-locating the decisions that affect individuals, their careers and families within the communities that serve them. [This paper] advocates a single, ring-fenced approach to the commissioning, designing and delivery of all health care services and the devolution of necessary funding and powers to the local level, in order to achieve this vision."[1]

The detail in the ResPublica report and the conclusions of the CPIER report both present a convincing case for devolution.

This is where health comes in. We have explored above how putting health at the heart of every decision should be a natural next step to ensuring the health of the people in this region is improved, and ensuring the health and care system is more sustainable for the future.

And while many of our own recommendations do not depend on devolution of health and social care, devolution would hugely accelerate progress. It could make the difference between an agenda that simply improves the health of its population and one that becomes an example for a totally new way of approaching public health.

There are numerous advantages to a devolved approach, centred around three key areas: devolved funding, devolved delivery and devolved authority. We frame it in such a way to acknowledge the feedback we had from people during our consultation work, who pointed out that devolution can mean different things.

DEVOLVED FUNDING

Devolving health and social care in this region would mean the establishment of a pooled budget for health and social care in this region. This would have several benefits. First, it would reduce the friction that occurs at points between different spending authorities and services.

The best example of this comes with the Continuing Health Care budget. When an individual is deemed to require care by the NHS, the cost is therefore covered (or in some cases, part-covered). If they do not qualify they then need to be assessed by local authority to establish if they are eligible for cover by them. This can lead to a great deal of back and forth between health and local government – not because the person does not need care, but because there is disagreement about who should pay for that care. Where parts of the system are particularly financially challenged this disagreement gets worse, because there is more at stake and more disagreement, at the centre of which is a family that needs care. Occurences of similar situations were raised in many of our conversations with leaders across the region. This was also a particular concern of Healthwatch, who frequently raise the issue of patient care being fragmented and confusing for the patient. It was also felt by many that any attempts to be more connected and joined up are often made impossible when either or both sides are financially challenged. As one of the Local Councillor's put it, "Money is always the issue, because nobody wants to trust anybody else with the money." In many ways, devolving the budget and pooling health and social care together is the only way to achieve true integration, and care being joined up at the point of use.

Devolved funding also allows local spending to be defined at the local level, according to local need. This would afford the region the power to better balance the budget towards prevention strategies, something which leads to better health of the people and significant financial savings (as we noted earlier in the report, see page 19). At present a miniscule proportion of health funding nationally is spent on prevention, while local authority cuts affect the ability of providers to focus on anything other than the minimum that is required of them. And yet, a focus on prevention is the only way to reduce the pressure on acute and primary services long term. It would allow the region to draw on the vast amount of information that it has about local needs, and prioritise spending to that which will have the most impact.

We have discussed earlier in this report the benefits to a prevention approach, and we reiterate here that it is the only way to achieve the long-term goal of a better, more sustainable healthcare system. It also captures and utilises the fantastic resources we have in organisations that deliver prevention strategies: the voluntary sector, local councils, employers and community organisations. These are not well embedded within the NHS approach at present. While local authorities are delivering much population health activity, they are also suffering from significant cuts to their budgets, particularly in public health. This is only going to be more significant in the years to come, as many local authorities are facing major financial pressure and public health budgets continue to suffer.

DEVOLVED AUTHORITY

The second key advantage to a devolved health and social care system is devolved authority. A devolved approach would allow the local region to define its own health and social care strategy, particularly in relation to prevention of illness, and to set KPIs at a local level. Many people we spoke to in our consultation period raised the issue of nationally-set targets and aims. This is particularly the case in health and wellbeing strategies. It was pointed out that the national aims and targets are not always appropriate for every part of the region. Prevention activities need to be far more targeted than they are, and the region needs to be able to use the data and knowledge available to it, to set meaningful, place-based targets. This is even more important in a region such as this, which is so defined by its difference. We outlined earlier in the report the importance of taking a localised approach to prevention. This does not depend on devolution, but a devolved approach would allow priorities to be set at a truly local level, in a way that is not possible at the moment.

DEVOLVED DELIVERY

The third key advantage to devolution is it enabling devolved delivery. It allows local organisations to design the organisational structures and governance frameworks that are best for delivering health and social care in their region. As we noted above (see page 38) central government and central NHS requirements set expectations for the existence of certain boards, groups, committees, and frameworks, which have to co-exist with the local parts of the system set up by the organisations themselves. This contributes to an overly complicated system, and the duplication we discussed earlier in the report.

While these three elements would provide a strong basis for devolution in Cambridgeshire and Peterborough, we believe they can be built upon. The current system has become a hindrance and there is a need for new ways of delivering care. The core advantage to devolution is, by definition, its ability to be place-based. Our further aim needs to be to get the resources and power as close to the front line as possible. It must not just be place-based but also local and community-led. Authority needs delegating to those with the knowledge, skills and experience that put them closest to the patient. – in short to specialists in local care provision.

The aim of a devolution bid in this region should not be to concentrate power and decision-making “up” to the Combined Authority or another overarching body. Devolution from central government must be done in order to further devolve power and responsibility “down” to the front line, to organisations that work within the community.

Generally, responses in our interviews around the possibilities of devolution were mixed. Some resistance came from the sense that a great deal of integration is already underway, and a concern that something new could undo that work. Some interviewees pointed to the relatively large size of the Combined Authority, its rural character (which they often contrasted with Greater Manchester), and the sheer complexity of the system, which would make implementing devolution extremely structurally challenging.

The biggest concern was, as always, funding. Some of the various parts of the system are so completely focused on budget or the deficit that it's impossible for them to see a way out. The bottom line for many interviewees was that "partnership is important, but we have to get the money right", or that "there isn't money for transformation". And while devolution could pull more investment into the system, there was also a lot of scepticism about how sustainable that would be.

Some interviewees were more positive about the idea of devolution, even if they were also concerned that it wouldn't ultimately be feasible. On the other hand, several pointed out that C&P is unusual in that it is the largest combined authority, and that the STP and CCG cover geographically the same area. This makes the prospect of bringing them together relatively administratively easy, and it would in theory be easy to see short-term improvements in efficiencies. Some even said the financial difficulties could be treated as a positive: "We have the greatest need to drive down costs and to save money. This gives us a reason for doing it, a real need for change on a major scale."

RECOMMENDATION:

- Develop and implement a holistic strategy designed to put health at the heart of every decision across all its areas of policy.
- Consider the appointment of a Health Champion at Director level within CPCA to work collaboratively with local authorities and all the statutory and non-statutory health and social care bodies to help realise the ambitions described in this report. The person appointed must have a track record of demonstrating a partnership approach and the ability to listen and exercise influence across boundaries. Success in the role would result in Cambridgeshire and Peterborough becoming a national leader in health and care.
- CPCA to take the lead, after consultation with the CCG, STP, and Public Service Board in seeking a combined health and social care budget, with both capital and revenue elements, that would be delegated to localised teams and to local authorities. Build on collaboration experienced during the crisis the new settlement would be designed to make such collaboration a way of life with a single budget covering spending in the region.

The devolution bid must commit to:

- Putting funding and powers as close to the front line as possible.
- Empowering and funding local authorities and the communities as the best delivery model for prevention approaches.
- Pool the budgets and authorise the CCG and STP to collaborate on delivery of health and social care, with requirement to localise as much as possible (e.g. through use of Neighbourhood Cares model of care).
- Rationalise duplication of bodies and oversight.

The Whole System: new ways of working and organising

A crisis can bring real and lasting change.

This Commission was asked to address best practice in the UK and globally, to consider new ideas that may be of value in improving services in the region. We have mentioned these throughout the report, and expand upon them here. In this final section of the report we focus specifically on how an innovative approach could help to bring about more sustainable and effective models of health and care.

Cambridgeshire and Peterborough is a region world-renowned for being rich in innovation – a knowledge economy that provides huge resource to help improve its people's health.

As we pursue new ways to support healthy lives and empower those working at the local level, we can and should be bold. We especially need to be more creative and ambitious with our approach to social care, in order to help those on the front line and integrate their work better with health care.

NEW MODELS OF CARE

Around the world there are excellent models which offer the promise of better value for money, services that are better at prevention and better focused on the needs of the individual user. Buurtzorg is a Dutch social enterprise that has caused a revolution in neighbourhood nursing and is starting to make a difference to the care system in the UK – including the Neighbourhood Cares programmes in St Ives and Soham, which was inspired by the Buurtzorg approach. This approach to care can and will make savings for acute care through prevention and de-escalation. We also believe that if the region were to expand the use of this model it could increase employment in the short and long term, as these roles attract a wider range of applicants and report high levels of job satisfaction and empowerment.

Buurtzorg is a nurse-led model of holistic care that has revolutionised community care where it has been used. The approach aims to facilitate independent living for people with care needs by mobilising teams of nurses into neighbourhoods. The teams consist of up to 12 nurses, each responsible for 40-60 clients. The nurse's role is framed as that of a 'trained informant' - their job is to provide clients with the assistance they need, whether practical or medical, but also to train clients and those around them to be able to practise self-care as far as they are capable. It has a proactive, rather than reactive approach, and places emphasis on the quality of care and the time nurses spend with clients. Making it work relies on teams being embedded within the community, empowered to make decisions, people-centred and place-based.

Academic research conducted in 2018[li] found that people with experience of prior district nurse services who had switched their care to the Buurtzorg model reported better continuity of care, easier contact with nurses and longer visits, and more thorough care for their issues. Carers meanwhile, reported higher job satisfaction, positive client feedback and better work-life balance. The scheme also improved and personalised relationships between the carer and those cared for. In addition to this academic case study there are numerous anecdotal case studies, the majority of which report positive results, including long-term financial savings, through either delivering better outcomes or delivering the same outcomes in a more cost-effective way. To have within this region a pilot of this approach is a huge asset, and one we believe should be built upon.

NEIGHBOURHOOD CARES PILOT

'Neighbourhood Cares' (NC) was an approach to social care that was piloted in Soham and St Ives by Cambridgeshire County Council, and inspired by the "Buurtzorg" approach to nursing. This pilot aimed to assess the viability and potential success of adopting the model across the region, informing the evolution of place-based models of social care during the transformation of the whole system.

The county council produced an in-depth assessment of the pilot at its conclusion, which we draw on here in the report to highlight its huge potential in the region. It concluded that *"the Neighbourhood Cares pilot has been a great success... It has provided a basis for knowing what really good place-based working in Adult Social Care looks like and has set the direction for the future, in a multi-agency context through the Think Communities approach. It has also shown what a collaborative approach between health and social care at a local level looks like. It has shown the benefits of setting up self-managed teams and allowing front line staff to build relationships at a local level and work flexibly to support people to prevent their needs from escalating and maintain independence."* [lii]

The evaluators also concluded that positive feedback on the service overwhelmingly outweighs feedback on its challenges and constraints.

Among the positive results from the pilot scheme were:

- High quality outcomes for people, including some outstanding holistic support and care for people and their families.
- Evidence of the non-escalation of clients' needs, including evidence of reduction in hospital admissions, reduction of loneliness indicators and reduction of transfer into residential care.
- Better self-reported quality of life for clients.
- Increased community capacity and community strength and resilience.
- Much higher overall job satisfaction, in large part thanks to employees' new sense of empowerment and their having the chance to see the difference they make; carers and other workers now have more direct contact with the people they help and reported stating that they felt it enabled them to "do the right thing, at the right time, in the right place".

Already there are some aspects of the pilot which have been adopted by public services in the region, in particular by adopting the principles of 'people, place and systems' within the Think Communities approach (outlined in detail earlier in this report). The learnings from the pilots are also feeding directly into the implementation of social prescription across all PCNs. The County Council is represented on the Cambridgeshire and Peterborough NHS Social Prescribing Board, and is developing a training and induction programme for all social prescribers to provide a person-centred, place-based offer of support to their respective PCNs.

In Soham a number of community assets were created and/or revitalised as a result of the pilot. This was more successful in Soham than in St Ives, mainly as a consequence of the more community-centric nature of the Soham delivery model. These assets include:

- Community lunches, from which the Soham Community Action group was formed.
- Drop-in sessions, whilst no longer branded as 'Neighbourhood Cares', are continuing with local authority support in both Soham and St Ives.
- Nellie the tuk tuk: funded through a Crowdfunder campaign run in partnership by a local arts group Viva, Soham Men's Shed and Neighbourhood Cares, the tuk tuk is available to transport local residents to community events and help to prevent isolation.
- Friendly Dogs: a drop-in that provides the opportunity for people to meet and socialise and to enjoy time with the dogs, for those who may not be able to have one of their own.
- A diabetes peer support group, providing an opportunity for diabetes sufferers to share their experiences and to help and support one another.
- 'Enhancing the Conversation' training delivered to library volunteers to equip them with skills that will help strengthen and deepen the (often very valuable) conversations they have with local residents.

The findings from the pilot provide an early guide for ways that NC could be implemented effectively in other parts of the region. One of the intended principles of the Buurtzorg approach is that it looks for and develops community strengths. This means that it is more effective when given the location and resource to develop community assets. For example, the pilot found that the team based in a library that served the community geographically closest to it was more effective than the pilot attached to a GP surgery. Despite the potential benefit of tying the Neighbourhood Cares work to a PCN with a link worker and social prescribing, the assessors of the pilot noted that because a GP population is larger and more geographically dispersed than a library's membership list, it limited the potential of the approach. They also suggest that there are benefits to being based in non-clinical settings. These are more conducive to drop-in activity than the doctor's surgery, which necessarily carries associations with clinical worries and an expectation or presumption of "need". This also contributes to our cautionary approaches to health and social care that rely on PCNs as the sole vehicle for delivery, as is suggested by ResPublica in their recommendations regarding devolved health and social care.

The pilots also began to generate a new approach to recruitment of teams, not previously used for council social care. By using an assessment-centre approach with scenario testing, they were able to find people well-suited to different roles from a broad range of backgrounds. This recruitment method brought together teams with the diversity of knowledge and expertise that suits a holistic approach to care and support. Effective and in-depth

training is also vital to the model's success, as much of its long-term benefits depend on empowering teams to make decisions. The time taken on training could also be vital to build relationships within the communities, allowing the teams to rely more on conversations and understanding of the community, and less on formal referral processes and systems.

While the findings of the pilot were largely positive, many of the advantages of a Buurtzorg-type approach are, by their nature, long-term. The advantages that the Buurtzorg model has seen and evidenced take several years to develop; the NC pilot was only 18-months long. Over time this model would be expected to see enormous dividend repayments in terms of outcomes, but some of the advantages could also only be realised fully if the approach were adopted at a larger scale and fully embedded in the context of an integrated approach to health and social care. For example, many of those involved in the NC pilot noted that their "health" colleagues were not included; it was delivered for and by social care and funded by the County Council under Adult Social Care. The involvement of both health and care could have resulted in a more joined-up approach for the user – for instance when it comes to the sharing of patient needs and entitlements data, where silo-ing is a recurring issue.

INVESTMENT IN NEW MODELS OF CARE

The success of a Buurtzorg-type model relies on approaching its work as a matter of care quality, not profit and savings. This was identified in the findings from the pilot, which state: "In proportionate terms, a Neighbourhood Cares pilot model with an optimal team would be more expensive than a business as usual model. Looking across the two areas combined, both the salary costs and the employee costs nearly double under an NCP optimal team structure. However, this only applies when looking at staff costs in isolation. The pilot was not able to fully test the benefits that would have been achieved by shifting significant Council back office costs to the front line as has been achieved with Buurtzorg which would have increased the affordability of the model. It should also be noted that this statement only considers costs to the Council and does not factor in the cost savings to other organisations, such as the NHS." [liii]

This perfectly summarises the drawbacks when any attempt is made to measure impact: projects led by one part of the system are only measured by how they impact that part of the system. While the estimated savings from the pilots came to less than the overall increased cost, longer-term and more holistic advantages such as: fewer GP visits, earlier discharges from hospital, lower demand for mental health services, reduced need for acute services and the increase in community strength and resilience, all have the potential to save a great deal of public money in the long run. These savings will be made from many parts of the system. It is impossible to assess the true benefits of an approach like Buurtzorg on a compartmentalised based.

In organisational terms, Buurtzorg approaches are designed to minimise bureaucracy. Performance monitoring is minimal and nurses are far more autonomous; overhead costs represent only a mere 8% of the total spend, compared with 25% paid by other home-care providers.[liv] By eliminating vast and costly bureaucratic bodies, a Buurtzorg approach can afford to incorporate more carers into the scheme, adding to the time nurses spend with clients and elevating the quality of care. Nurses are responsible for the assessment of patient needs, the development and implementation of care plans, and scheduling medical visits as needed. They also generate the documentation needed to facilitate continuous care and billing.

The sheer complexity of any health and care system means that success in one part of the system will result in a saving for another part of the system. If we judge individual initiatives based solely on whether they save money directly without factoring in the "hidden" savings in other areas, we will be unable to make potential long-term improvements across the system as a whole. Equally, the compartmentalised nature of the evaluation represents a strong argument for combined budgets and the devolution of authority, as we argue earlier in this report (see page 45).The value of Buurtzorg nurses/carers also increases as time goes on, as their being more embedded in the community means they become aware of those who may benefit from their services before acute need arises. Given the abundant positive evidence from Buurtzorg and other Neighbourhood Cares sites, it is disappointing to see these pilots not being taken forward, and we believe this must be re-considered.

RECOMMENDATION: Expand the Neighbourhood Cares initiative across the region, building on the learning identified by the pilots in St Ives and Soham. Prioritise opportunity areas for health, such as Peterborough and Fenland. If funding allows, conduct research into the potential savings from this approach when budgets are combined and back office staff redeployed.

STRONGER CAREER PATHS AND BETTER VOCATIONAL EDUCATION FOR PAID CARERS

Bringing the skills, employment and health and care agendas together, another opportunity is presented by the region focusing on improving career paths both into and within care.

Whilst not perfect, the training and education in place for nurses is well organised. Continuing Professional Development (CPD) is a contractual requirement of nursing roles; similarly, Health Care Assistants in NHS or charitable healthcare settings such as hospices benefit from well-organised training, and they can usually benefit from opportunities such as apprenticeships in nursing. Care homes, by comparison, struggle with training and development. There is the Gold Standard Framework which if followed, requires the care and nursing homes to train their staff to a particular standard. It is a practical, systematic, evidence-based approach to optimising care for all people nearing the end of life, given by generalist front-line care providers. However, it can make staffing costs prohibitively expensive for care homes, in a sector that is already financially squeezed. The government's plans for a UK points-based immigration system[lv] will also have a significant impact on the sector, leading to the potential of another crisis, with care providers struggling to recruit teams; one in six of care workers in the UK are non-UK nationals. The points system requires a minimum pay threshold of £20,480, which will be a barrier to migrant care workers and home carers, given that average pay is £16,500 per year. Care work will also not meet the skills threshold for the new Health and Care Visa, which is applicable for health professionals, nurses and doctors, but not care workers.

The Combined Authority has already started to address unemployment through skills initiatives. The Health and Care Sector Progression Academy aims to help train around 2,100 people across Cambridgeshire – including disabled and older people – to secure jobs in the industry. That total includes 600 new apprenticeships, with the hope that many will progress into full-time work in health and social care. Improving employment in this area will have a knock-on effect, not just helping improve local care provision, but boosting the health of the area and of the newly employed individuals themselves. The hope of the Neighbourhood Cares work was that it would offer employment for local people; indeed, the community benefits of the model are even more potent if employees live within the community.

We found some evidence that recruitment in some parts of the health and care system may have been boosted by the impact of coronavirus. A care home chief executive whom we interviewed for this report told us about a Hospice at Home initiative that had been in planning for several years. When the outbreak's impact was peaking, she told us, the initiative was confirmed, and whereas previously these roles had been difficult to recruit – particularly in the Fens – this time, the hospice had no problem filling the roles. She suggested that there being more people looking for jobs in the current climate, as well as a change in public attitudes towards care work, make it more attractive, at least temporarily.

The coronavirus and its aftermath are anticipated to have a potentially catastrophic impact on people's futures. The pandemic has already led to massive job losses in certain sectors, and a generation of school leavers will now have difficulty finding employment of almost any kind. The CPCA should treat this as an opportunity – as a skills gap to be closed by training these individuals to work in sectors such as health and social care. During the period of time of the work of this commission the Combined Authority announced the plans in place for the University of Peterborough, focusing on addressing the skills gap in Peterborough and developing a pipeline of employees in areas that are likely to struggle, one of which is health and social care.

RECOMMENDATION: Build on existing Further Education and Higher Education activity in the region to create new pathways of education and development and a growing supply of home-grown skills to health and social care, with a particular focus on social care. Proactively recruit to fill vacancies, using a targeted campaign across health and care sectors.

DIGITAL INNOVATION

The pandemic brought into sharp relief the benefits that can come from a more digital NHS. The use of video calling and other software to enable virtual connection, consultation and care has given both users and providers of services vital encouragement to embrace digital innovation. The Cambridgeshire and Peterborough Clinical Commissioning Group's 'Big Conversation' – a consultation conducted between September and December 2019 – found that only 11% of people thought that follow-up appointments after a treatment could be undertaken face-to-face, while 41% would be happy for that follow up to be a telephone or video call with a health professional.[lvi]

Covid has made a huge impact on digital innovation in the NHS and the care sector. Towards the end of the work of this commission during the pandemic we heard stories of 'three-year digital strategies being implemented in three months'. There is a great sense that the 'genie is out of the bottle'; now that organisations and patients have realised the potential in digitised approaches, and there will be no going back. The changes wrought by the pandemic have also shifted power: service users now have a much greater say in their health care access and delivery, and they also have new expectations. The service used to say how health care should be delivered. Now it is more often the patients who will decide. The government has also included reference to telemedicine in its recovery plan, saying it will "seek innovative operating models for the UK's health and care settings, to strengthen them for the long term and make them safer for patients and staff in a world where Covid continues to be a risk. For example, this might include using more tele-medicine and remote monitoring to give patients hospital-level care from the comfort and safety of their own homes". [lvii]

The traditional clinical model is set up on the assumption that a face-to-face consultation is the best approach for all patients. Clearly this is not always so. The use of telemedicine, for instance, may be entirely inappropriate for one patient but hugely convenient for another. Evidence is already emerging that telemedicine consultations can often be of better quality than a hospital appointment. People are more relaxed in their own homes. They can be seen with their children. Doctors can often understand a patient's case better with a glimpse of the home environment. Digital services need to be delivered in homes, in care homes and in the community. The provision of digital innovation needs itself to have a community-focused, population health approach. This will mean not only ensuring digital access, but a holistic digital approach that makes care records accessible, that promotes wellbeing, that encourages video interventions, and that is within the community.

Several respondents – including the chair of a local NHS Trust and a chief executive of a local care home - told us that the move to more flexible team working and a preference for video or conference calling was making a huge difference to the efficiencies of their community nursing and care teams. Given the issues parts of the region have with congestion – particularly at the current time, with a great deal of construction and development underway – the move to virtual meetings has been transformative. This is particularly the case in community and multidisciplinary teams, where regular communication is a vital part of delivery and effectiveness. The time saved by not travelling is time that can be spent with patients, with no loss of quality of care. Everyone benefits as it also reduces congestion on the roads while improving care for patients.

Technology can also support wider wellbeing in other ways. There is a significant concern in this region and nationally about the long term impact of the lockdown restrictions on people's mental health; this is an area technology may be able to support better. There has been the increased usage of video conferencing tools for mental health therapies and diagnosis, which may also make therapies cheaper and more easy to access. While there is still some way to go, the use of video for therapy has become more common, and is being recommended by the major professional bodies, such as the British Association for Counselling and Psychotherapy (BACP), the UK Council for Psychotherapy (UKCP) and the NHS. The chair of the Cambridgeshire and Peterborough NHS Foundation Trust told us that, while there are major concerns with the impact of Covid on mental health, the increased use of technology must be continued where it worked for patients, making access to therapy more flexible. There is some anecdotal evidence that it leads to increased participation, with patients less likely to miss sessions when they are offered virtually. Similarly care homes are using technology more widely for video calling between residents and their families. Continuing this usage not as a Covid precaution but a new way of doing things could allow residents in care homes greater contact with more family members and friends, greatly improving their general health.

DATA AND INFORMATION

A truly digital health and care system is about more than remote communication between patient and provider. The region is rich in high quality data and insights into our population's health and wellbeing needs. Many parts of the system are in some ways data rich, but data exists in silos. In an effective digital transformation these silos will be removed locally and regionally, to support population health.

The experience of the Neighbourhood Cares pilot was that a lack of data sharing across boundaries (particularly between health and social care) is a barrier to patient experience. The different systems that health and care professionals use need to be better joined-up, giving a full picture about a person's needs, support required and what is available to them.

There is an understandable anxiety in local authorities about the proper sharing of data about a person's needs. The system needs to be redesigned in a way that facilitates approaches that put the individual at the heart of the process.

Use of place-based data on a truly local level to develop information could give an accurate picture of population needs, and underpins prevention approaches. Cambridgeshire Insight is a shared research knowledge base for the Cambridgeshire and Peterborough area, and a huge asset. It allows people and organisations an easy way to access and share information and obtain deeper insights about their local area. This includes local population estimate and forecasts, Joint Strategic Needs Assessments, which is used to inform the local Health and Wellbeing Strategy.

Five hundred datasets are currently being brought together to create a tool to inform decision-making, service design, delivery and realign resources, hosted by Cambridgeshire Insight. This includes health data, demographic data, data about jobs, benefits and local assets. The intention is to design tools that make relevant local place-based data available for place-based boards to support intelligence led conversations. The Cambridgeshire and Peterborough Health and Wellbeing strategy draws heavily on these data. To have within the region such a clear picture of localised needs for that information to be held centrally by one organisation, is a huge asset for developing needs assessments in the region.

DIGITAL DEPRIVATION AND INEQUALITIES

Technology is a means of empowerment. It can enhance personal independence and reduce inequality. There are concerns that the impact of lockdown and the ensuing move to digital and telephone services will further disadvantage groups who do not have or cannot afford this access, or who do not have the digital literacy required to access services effectively.

Nearly two million households in the UK have no access to the internet.[lviii] Sometimes this is due to individual financial reasons (not being able to afford it) and sometimes geographical (living in areas where there is no or poor internet access). An additional 25.9 million people are on pay-as-you-go mobile contracts, making internet access at times prohibitively expensive. Vulnerable groups such as elderly people, asylum seekers and refugees and households living in poverty are hit hardest by more expensive pay-as-you-go tariffs because they generally cannot afford Wi-Fi at home or fixed-term contracts. This limits access to health services and information.

Poor digital access also hinders access to employment and education – which in turn undermines health. In particular the lack of sufficient access to technology and the internet has had a major negative effect during lockdown. While in the region we heard some cases of colleges and schools providing laptops and WiFi dongles to some young people, this provision has been patchy. There are also those in difficult home situations where access to their phones or internet is restricted or monitored by a partner or family member, or who cannot count on the privacy they can count on in face-to-face contact.

Digital access also depends on digital literacy. Four million people in the UK have never used the internet and 12 million do not have the digital skills to access the digital world beyond perhaps email or a shopping app.[lix] Technological innovation must be accompanied by an effort to drive up digital literacy and end digital deprivation.

DIGITAL AND SOCIAL INCLUSION

The Good Things Foundation, the UK's leading digital inclusion charity has outlined the factors that contribute to a digital inclusion network. This is drawn from their work with local authorities in Salford, Leeds and Stockport, to develop local digital social inclusion networks in their communities. These approaches require:

- Buy-in from all local stakeholders, with a joined-up approach.
- Digital Inclusion Ambassador. A person or local organisation that takes on the role of ambassador for digital inclusion. The focus of this role is to build the capacity of local organisations, especially the voluntary sector to incorporate digital inclusion into the services they offer so that digital is "built-in" rather than "bolted on". A good example of this is a community organisation that runs a walking group and uses digital communication with the group to plan routes. The ambassador is also important for joining up what's going on locally so that organisations can work together.
- The role of community organisations and the voluntary sector. Voluntary sector organisations are experts at engaging with the people who can most benefit from the internet – those who have low or no digital skills and tend to be experiencing poverty and inequality. These organisations are the trusted faces in communities. They provide a safe place to people in crisis and a place to go for people who are lonely and isolated. They are key players in the area of digital social inclusion.

Voluntary sector organisations are facing significant funding challenges as a result of years of austerity and now the impact of Covid is adding to these challenges. To ensure that the voluntary sector can play a role in tackling digital exclusion, it is important to find a way to fund them to do so. For example, Leeds City Council, through its 100% Digital Leeds programme, secured funding for a digital inclusion small grants programme. Furthermore, local voluntary sector organisations often have old and outdated digital devices and poor connectivity which limits their ability to support people in their communities to gain digital skills and confidence. 100% Digital Leeds has set up a tablet lending scheme for organisations in Leeds to borrow iPads to use with digitally excluded adults so that they can gain skills and confidence.

Access to mobile data in the area has improved significantly over the last few years. Fenland in particular has increased access to 4G: 91% of residents in Fenland have access from three or more networks, compared with less than half in 2018.[lx] We have seen evidence of corporate sponsors and community groups and volunteers being able to help with this, and lead on projects to address the needs of the socially deprived. One care home chief executive told us that they had been contacted with an offer of a number of Facebook Portals for their residents to use. Such collaborations and partnerships can be empowering on an individual basis, but are not consistent.

The voluntary sector could also help here, building on the goodwill mobilised during the pandemic, with local community and mutual aid groups potentially providing an excellent digital and technological support base for neighbours. This could also be a role for the hugely under-utilised NHS volunteers; delivering a device preloaded with apps and material about how to video conference and email, for instance, and keeping in touch on a weekly basis to check progress.

RECOMMENDATION: Endorse the digital approach to health and care. Work with community and voluntary sector, and the education and skills agenda at CPCA, to map and increase digital access and literacy across the region.

LEARNING FROM COVID

The response to the pandemic in this region was impressive, particularly in relation to the levels of innovation and new ways of doing things. It proved to be a testing ground for a community-focused, localised response to a crisis. It also forced through integration, digital innovation and collaborative working at a great speed. In the conversations we had with leaders through spring and summer of 2020, we heard great enthusiasm for continuing this collaboration, and for using it as a way to do things differently going forward. At the same time there is huge anxiety about what is to come: financial pressures on public services, the long-term health impacts of the crisis caused by treatments being delayed or not delivered, and the significant mental health impact of the lockdown.

Overall, there needs to be a proactive approach to documenting what has worked well and what has not. Failures can offer tremendous points of learning for the future, and there is an opportunity to build on the learnings and the leap forward that has been taken by al parts of the system. Data on what has worked and what hasn't has been collected by many parts of the system and different providers, but the CPCA could be instrumental in asking organisations to submit reports to aggregate this learning. This should be done in collaboration with the CCG, STP and Public Services Board, who reported working much more closely together during the crisis, and have begun plans to continue to do so.

We have outlined above the learnings in relation to digital transformation that can come out of the crisis. Below we also outline some of the learnings we heard around the importance of a community focus.

THINK COMMUNITIES IN ACTION

Think Communities is a way of approaching public services across Cambridgeshire and Peterborough, which formalises a person-centred model. This way of leading public services in this region is intended to encourage individuals to look after themselves and their own community better, and to ensure as much as possible that where they need to access services, they do so within the community rather than via acute and/or hospital services. There has been a great deal of work to embed this across public services in the region, and the pandemic provided a test for how this would work in practice in crisis management, rather than in delivery of service.

From the first government announcements about Covid Covid (16th March 2020 onwards) the Think Communities approach was central to the region's response at a council level. The think communities team started with an ideas-shaping meeting, looking at volunteer coordination, a hardship fund, and building community reference groups. Central government brought in a national mandate for county councils to create 'Hubs' for Covid responses with clear guidelines on what that needed to cover. This was, in part, to provide a package of support for those shielding. This gave the council team 48 hours to get the hub live. It missed the opportunity to allow each hub to use its local knowledge and judgment. One of the team noted that: "From a Think Communities perspective, that was probably our most testing few days, because we had to work in a way that really goes against how we've been trying to work the last two years: we had a mandate from the top and we just had to get on with it and we didn't have time to engage with districts on how we did it."

Work since has had to focus on repairing relationships and acknowledging the need to work collaboratively going forward. It is important for those at the centre to understand how wasteful it can be when local initiatives are discouraged.

The county council was responsible for taking care of those people who were 'shielding' : responding to their health and wellbeing needs, including food delivery, medicine, wellbeing and library provision. The county council team was also therefore running logistics and warehouse operations to ensure delivery of additional food parcels. The warehouse was 'loaned' by a private company, Urban&Civic, a testament to local authority and business collaboration.

The District Council representatives were responsible for the more localised community needs and responses. There was an acknowledgement in our conversations that this division worked well – acknowledging that local councils on smaller scales are best placed to provide this community response. The experience reinforces the conclusion that those closest to the community are the best placed to identify needs. The way that different communities responded has been different too. South Cambridgeshire has lots of villages, Cambridge City has a stronger ward structure; Peterborough has the most significant issue with rough-sleepers, who were a high focus point of the coronavirus pandemic response nationally, being at extremely high risk.

Regular communication channels were set up between all local councils on a weekly basis, encouraging communication, sharing information and examples of approaches. The working environment was positive, with acknowledgement that no one person was the expert and everyone was out of their comfort zone. This has led to greater collaboration and mitigated against defensiveness. There was much less ownership of ideas, and teams are more motivated to support each other.

The tensions or frictions that existed before between different providers of public services have not disappeared, but many felt that the crisis forced all concerned to deal with them better than before; communicate better and work together better. Where previously there are areas of disconnect between county councils, district councils and health and NHS organisations, during the crisis there was more of a drawing together of local organisations and a larger disconnect between local actors and national government. This was particularly the case where there were mixed messages or a lack of national guidance. For example, one of the key responses to the crisis was for the local councils and voluntary sector to mobilise and organise the groundswell of volunteers in communities. The local councils in this region had already begun to work with the local hospitals and NHS organisations on how these volunteers could be engaged to support their work, too. The UK government then announced a nationwide NHS volunteers scheme, which was not communicated to local organisations. Despite millions of people signing up to the scheme, it was poorly used, and the local mutual aid groups and voluntary sector were far more active during the lockdown. Once again there is a lesson here for central government: local initiatives have on-the-ground effectiveness and judgement that the centre does not. Regional and local organisations should be trusted to deploy these qualities.

Internally in public services, several people told us that the mass re-deployment within the council has also encouraged a move away from people feeling they are 'just an employee in a team with a specific role and into more of a feeling of understanding themselves as a part of a whole system of public service. For the workforce it has been a real eye-opener in terms of their role as part of a public sector rather than as part of a team that doesn't engage with other departments. Some work is being done internally to capture and foster this going forward, and it is crucial that this sense – of public services being for the community and for a common good – be fostered and continued.

Another impact of the Covid response at the front line was the speed with which decisions had to be made, and the empowerment this provided, and a more mature approach to risk. Within the public services themselves decisions could be made quickly and without having to resort to the bureaucratic relationship. For instance, one council employee told us that, "We have always had the main goal that we need to keep people well and safe and happy, it's never been pulled together in the same way that this [Covid] is forcing us to. People are so much more accepting and willing to try things, and it feels more like a collective rather than pulling against each other." In some cases, this was due to their being no budgetary constraints: the message from central government was for councils to 'spend what they need to to keep people safe'. In this way of doing things there simply was not time to go through the traditional hierarchical decision-making chain.

This has been largely positive: where decisions are getting made quickly, people are then able to see that those decisions have been made and there aren't negative consequences: people are able to 'take risks' on decision making, and by doing so realise that it was never really a risk in the first place. This leads to a realisation that sometimes decisions don't always need to be approved at multiple higher levels, and there is space to do things differently.

RECOMMENDATIONS:

Formalise the learnings from Covid as they relate to the delivery of public services. This should include:

- The better collaboration and working of health and care systems.
- Build on the success of projects such as 'Neighbourhood Cares' and approaches such as 'Think Communities' empowering communities.
- Rationalisation of governance: use the Covid response as an opportunity to rationalise and simplify boards, bodies, identify duplications of agendas, people and consolidate into more effective and efficient governance models.
- Put emphasis on the CCG, STP and Public Service Board and Combined Authority being aligned, not just co-operative.
- Take advantage of the recent technological innovation and its use in health and social care, brought about by the Covid crisis.

Recommendations – Summary

THE WHOLE PERSON

- The CPCA should endorse a localised approach to prevention to achieve population health. This should include:
  - Equipping local authorities with the data, resources and mandate to identify the largest health risks and operate relevant campaigns in partnership with relevant commissioning groups and public health bodies.
  - Encourage partnerships with the private sector to draw on innovative approaches to prevention.
  - Working with relevant partners to explore ways of strengthening the local and regional supply chain of high-quality, locally-grown food. This should include growing and cooking at a local level. It could also include selling in local food outlets. Partnership arrangements should be discussed with retailers who would be sympathetic to the healthy food, good nutrition message.
- The CPCA should identify and focus on 'opportunity areas' for health, particularly in the North of the region, diverting resources to the local council and communities to focus on prevention.
- The CPCA should engage employers around their teams' health, particularly mental health, given its proven relationship with productivity.
- All plans for health and social care for the future should be focused on integration, and ensuring care is joined up at the point of use.

THE WHOLE COMMUNITY

- The CPCA prioritise making local organisations - local authorities, district, city, town and parish, communities - the delivery mechanism for wellbeing strategies. Invest in them, acknowledging that investment does not always mean financial support. Encourage the use of innovative and sophisticated prevention approaches, including drawing on the vast resource of the private sector.
- The CPCA should endorse and where possible enact innovative approaches to procurement to ensure these relationships are built well, such as the Trust Test to ensure appropriate outsourcing.
- The CPCA should embed and endorse a localised, mixed economy approach to care and wellbeing in the community – using public, private and third sector.
- The CPCA should prioritise making local organisations- local authorities, district, city, town and parish, communities — the delivery mechanism for wellbeing strategies. Invest in them, acknowledging that investment does not always mean financial support. Encourage the use of innovative and sophisticated prevention approaches, including drawing on the vast resource of the private sector.
- NHS and central government (the Department of Health and Social Care) should adopt a less centralised approach. This should concentrate on national policy frameworks to empower and liberate local government to deliver in their own ways.

THE WHOLE REGION

- Develop and implement a holistic strategy designed to put health at the heart of every decision across all its areas of policy.
- Consider the appointment of a Health Champion at Director level within CPCA to work collaboratively with local authorities and all the statutory and non-statutory health and social care bodies to help realise the ambitions described in this report. The person appointed must have a track record of demonstrating a partnership approach and the ability to listen and exercise influence across boundaries. Success in the role would result in Cambridgeshire and Peterborough becoming a national leader in health and care.

Make health a strategic measure and consideration in all aspects of the Combined Authority's strategy, with particular focus on: long term investment in prevention and building infrastructure that enables health and social care to be more integrated and community based. Use learnings from the Healthy New Towns and Blue Zones.

- Commit to developing more Healthy New Towns, and adopting principles of Healthy New Towns for development in existing places. This should include health partners in planning discussions.
- The Combined Authority's Local Transport Plan policies for 'Creating Healthy Thriving Communities' need to be implemented throughout, and the implementation monitored.

- The CPCA should be briefed regularly on the relevant indicators identified by the local Health and Wellbeing Board to inform all policies that can have an impact on the health of individuals and the resilience of communities. The design of any future decision-making structures should ensure that these indicators are agreed and reviewed regularly.
- CPCA to take the lead, after consultation with the CCG, STP, and Public Service Board in seeking a combined health and social care budget, with both capital and revenue elements, that would be delegated to localised teams and to local authorities. Build on collaboration experienced during the crisis the new settlement would be designed to make such collaboration a way of life with a single budget covering spending in the region.

The devolution bid must commit to:

- Putting funding and powers as close to the front line as possible.
- Empowering and funding local authorities and the communities as the best delivery model for prevention approaches.
- Pool the budgets and authorise the CCG and STP to collaborate on delivery of health and social care, with requirement to localise as much as possible (e.g. through use of Neighbourhood Cares model of care).
- Rationalise duplication of bodies and oversight.

THE WHOLE SYSTEM

- Expand the Neighbourhood Cares initiative across the region, building on the learning identified by the pilots in St Ives and Soham. Prioritise opportunity areas for health, such as Peterborough and Fenland. If funding allows, conduct research into the potential savings from this approach when budgets are combined and back office staff redeployed.
- Build on existing Further Education and Higher Education activity in the region to create new pathways of education and development and a growing supply of home-grown skills to health and social care, with a particular focus on social care. Proactively recruit to fill vacancies, using a targeted campaign across health and care sectors.
- Endorse the digital approach to health and care. Work with community and voluntary sector, and the education and skills agenda at CPCA, to map and increase digital access and literacy across the region.
- Formalise the learnings from Covid as they relate to the delivery of public services. This should include:
  - The better collaboration and working of health and care systems.
  - Build on the success of projects such as 'Neighbourhood Cares' and approaches such as 'Think Communities' empowering communities.
  - Rationalisation of governance: use the Covid response as an opportunity to rationalise and simplify boards, bodies, identify duplications of agendas, people and consolidate into more effective and efficient governance models.
  - Put emphasis on the CCG, STP and Public Service Board and Combined Authority being aligned, not just co-operative.
  - Take advantage of the recent technological innovation and its use in health and social care, brought about by the Covid crisis.

Appendix

TERMS OF REFERENCE

- Objective and independent advice and critical thinking on ways to make the public sector in Cambridgeshire and Peterborough more effective, responsive and financially stable in the future, and in particular to consider the scope for bringing services closer to the people and communities they serve in individual places;
- Consider evidence on the likely future demands on public services, on developments in technology and practice, and on future trends in public revenue to fund services;
- Consider new ideas, innovation proposals and best practice from elsewhere both in the UK and globally, that may be of value in improving services in Cambridgeshire and Peterborough:
- Make recommendations for achievable reforms to the way public services are delivered and funded, paying particular attention to the scope for bringing services closer to the people and communities they serve in individual places;
- Bring forward suggestions and recommendations about the levers that the Mayor and Combined Authority can influence to support delivery of the Commission's recommendations;
- Support the Combined Authority in making the case for public sector reform;
- Secure input from local partners, government departments, business, academia and subject experts to support the Combined Authority in making the case for public sector reform;
- Promote and foster a common understanding of the future development of the reform programme in support of the area's wider economic and social ambitions and the long-term drivers for change.

MANDATE

Provide objective and independent advice and critical thinking on ways to make the public sector in Cambridgeshire and Peterborough more effective, responsive and financially stable in the future, and in particular to consider the scope for bringing services closer to the people and communities they serve in individual places. Our focus in the first instance being health and social care.

COMMISSIONERS

Craig Dearden-Phillips MBE
Mark Goyder
Dr Lynn Morgan
Professor Clive Morton OBE, Ph.D, CCIPD
Lynne Walker
Dr Andy Wood OBE DL

PROJECT TEAM

Dr Scarlett Brown
Oliver Drury

VERSION CONTROL

SBODHT/5

Footnotes

EXECUTIVE SUMMARY

[i] Healthwatch Cambridgeshire Strategy, 2020.

[ii] Detailed continued in our Full Report

[iii] Ibid.

[iv] See www.buurtzorg.com for more information and publications.

[v] Cambridgeshire and Peterborough Health and Wellbeing Board joint Strategy (Draft), 2020.

[vi] See https://www.bluezones.com/blue-zones-project-results/

[vii] Creating Healthy Places, The Kings Fund. 2018.

FULL REPORT

[i] Healthwatch Cambridgeshire Strategy, 2020. https://www.healthwatchcambridgeshire.co.uk/sites/healthwatchcambridgeshire.co.uk/files/2020-2025%20strategy%20final%20-%20for%20web.pdf

[ii] Ibid.

[iii] NHS Five Year Forward View, 2019. https://www.england.nhs.uk/wp-content/ uploads/2014/10/5yfv-web.pdf

[iv] https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document

[v] 'The Health of the Nation: a strategy for healthier longer lives'. All Party Parliamentary Group for Longevity, February 2020. https://appg-longevity.org/events-publications

[vi] Multiple references. See for example https://www.sciencemag.org/news/2020/09/why-Covid-more-deadly-people-obesity-even-if-theyre-young

[vii] Is an Ounce of Prevention Worth a Pound of Cure? Estimates of the Impact of English Public Health Grant on Mortality and Morbidity, Centre for Health Economics, Research Paper 166. https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP166_Impact_Public_Health_Mortality_Morbidity.pdf

[viii] Healthwatch Cambridgeshire Strategy 2020 https://www.healthwatchcambridgeshire.co.uk/sites/healthwatchcambridgeshire.co.uk/files/2020-2025%20strategy%20final%20-%20for%20web.pdf

[ix] Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy 2020-2024, Consultation Draft published 7th February 2020. Available https://www.peterborough.gov.uk/council/consultations/joint-health-and-wellbeing-strategy-for-cambridgeshire-and-peterborough

[x] Active Lives Adult Survey, December 2019. Sport England. Summary available here: https://www.livingsport.co.uk/Handlers/Download.ashx?IDMF=f71121bc-691c-4dbd-809c-0fe461a21518 Full report here: https://www.sportengland.org/know-your-audience/data/active-lives

[xi] Cambridgeshire CC, 19.6%; Oxfordshire 15.9%, Surrey 8.8% - Percentage of people who have cycled for travel at least twice in the last 28 days. Data from Active Lives Adult Survey, December 2019.

[xii] Creating healthy places: Perspectives from NHS England's healthy New Towns programme. The King's Fund, September 2019. https://www.kingsfund.org.uk/publications/creating-healthy-places

[xiii] Cambridgeshire and Peterborough Independent Economic Review, Final Report, 2018, p.94. https://www.cpier.org.uk/media/1671/cpier-report-151118-download.pdf

[xiv] Cities Outlook 2018, Centre for Cities, 2018. https://www.centreforcities.org/publication/cities-outlook-2018/

[xv] Cambridgeshire and Peterborough Independent Economic Review, Final Report, 2018, p.94.

[xvi] Cambridgeshire's Annual Public Health Report 2019. Cambridgeshire County Council. https://cambridgeshireinsight.org.uk/wp-content/uploads/2020/01/CCC-APHR-2019-final.pdf

[xvii] Cambridgeshire and Peterborough Independent Economic Review, Final Report, 2018, p.101.

[xviii] Healthwatch UK, What people want from the next ten years of the NHS https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20200128%20-%20What%20people%20want%20from%20the%20next%20ten%20years%20of%20the%20NHS.pdf

[xix] Healthwatch Cambridgeshire and Peterborough. Focus on experience: accessing mental health support. https://www.healthwatchpeterborough.co.uk/sites/healthwatchpeterborough.co.uk/files/06%20Mental%20Health%20report.pdf

[xx] https://www.camerados.org/join-the-movement/

[xxi] Creating healthy places: Perspectives from NHS England's healthy New Towns programme. The King's Fund, September 2019. https://www.kingsfund.org.uk/publications/creating-healthy-places

[xxii] More information about the Controlling Migration Fund available here:https://www.gov.uk/government/publications/controlling-migration-fund-prospectus

[xxiii] Our thanks to Fenland District Council for providing the detail for this Case Study.

[xxiv] See www.cambridgefoodhub.org

[xxiii] Our thanks to South Cambridgeshire District Council for providing these examples

[xxvi] Devo-Health: a new approach to the public's health in Cambridgeshire and Peterborough. A report by ResPublica for the Cambridgeshire and Peterborough Combined Authority. January 2019.

[xxvii] https://www.civilsociety.co.uk/news/charities-face-closure-as-sector-set-to-lose-4bn-over-12-weeks.html

[xxviii] https://www.institute-of-fundraising.org.uk/news/coronavirus-impact-survey-results-charities-cannot-meet-the/

[xxix] British Standards Institution. https://www.bsigroup.com/en-GB/standards/bs-95009-procurement-in-the-public-sector/

[xxx] Tomorrow's Business Forms, Tomorrow's Company, 2013. https://www.tomorrowscompany.com/tomorrows-business-forms/

[xxxi] British Standards Institution. https://www.bsigroup.com/en-GB/standards/bs-95009-procurement-in-the-public-sector/

[xxxii] Small and Medium Enterprises

[xxxiii] In South London for example, the local facebook group and forum 'Nunhead Rocks' formalised its role in the Covid-response by setting up 'Nunhead Knocks' https://www.nunheadknocks.com/ with a formalised triage system in place that coordinates local volunteers and builds communities.

[xxxiv] https://www.theguardian.com/world/2020/may/03/nhs coronavirus-crisis-volunteers-frustrated-at-lack-of-tasks

[xxxv] https://www.huffingtonpost.co.uk/entry/test-and-trace-local-authorities_uk_5f2bebd8c5b6e96a22ae9dd4

[xxxvi] Buettner, Dan (2010). Blue Zones: Lessons for Living Longer from the People who have lived the Longest, National Geographic. See also https://www.bluezones.com/

[xxxvii] Creating healthy places: Perspectives from NHS England's healthy New Towns programme. The King's Fund, September 2019. https://www.kingsfund.org.uk/publications/creating-healthy-places

[xxxviii] Putting Health Into Place, Summary of learning from Healthy New Towns. https://www.england.nhs.uk/wp-content/uploads/2019/09/phip-executive-summary.pdf

[xxxix] Ibid.

[xl] Older people's housing, care and support needs in Greater Cambridge 2017-2036, Sheffield Hallam University, November 2017. https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/older-peoples-housing-care-support-greater-cambridge.pdf

[xli] https://www4.shu.ac.uk/research/cresr/news/housing-older-people-supply-recommendations-hopsr

[xlii] https://wintringham.org/

[xliii] Healthwatch Cambridgeshire and Peterborough Focus on experience: Accessing mental health support https://www.healthwatchpeterborough.co.uk/sites/healthwatchpeterborough.co.uk/files/06%20Mental%20Health%20report.pdf

[xliv] Report to Health and Wellbeing Board, March 2020. https://cambridgeshire.cmis.uk.com/CCC_live/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=FCOTn7za-Jebve8E6cAu5CHS2qb9vfZCL1Pv5XTeeVdJ8DQyXRl0F-MA%3d%3d&rUzwRPf%2bZ3zd4E7Ikn8Lyw%3d%3d=p-wRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%-2fLUQzgA2uL5jNRG4jdQ%3d%3d&mCTIbCubSFfX-sDGW9IXnlg%3d%3d=hFflUdN3100%3d&kCx1AnS9%2f-pWZQ40DXFvdEw%3d%3d=hFflUdN3100%3d&uJovDx-wdjMPoYv%2bAJvYtyA%3d%3d=ctNJFf55vVA%3d&Fg-PlIEJYlotS%2bYGoBi5olA%3d%3d=NHdURQburHA%3d&d-9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55v-VA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctN-JFf55vVA%3d&WGewmoAfeNQ16B2MHuCpMRKZMwaG-1PaO=ctNJFf55vVA%3d

[xlv] Data from the LaingBuisson Care of Older People UK Market Report 30th Edition 2019, featured by PayingForCare.org https://www.payingforcare.org/how-much-does-care-cost/

[xlvi] Story covered by the Cambridge Independent, further detail provided by members of the Cambridgeshire Carers Alliance. https://www.cambridgeindependent.co.uk/business/ccl-offers-500-Covid-tests-a-day-for-care-homes-in-cambridge-region-9111762/

[xlvii] https://cambridgeshirecares.org/

[xlvii] Cambridgeshire and Peterborough Devolution Deal

[xliv] Final Report, CPIER, 2019.

[l] Devo-Health: a new approach to the public's health in Cambridgeshire and Peterborough. A report by ResPublica for the Cambridgeshire and Peterborough Combined Authority. January 2019.

[li] Drennan et al. (2018) "Tackling the workforce crisis in district nursing: can the Dutch Buurtzorg model offer a solution and a better patient experience? A mixed methods case study", BMJ Open 8(6). http://dx.doi.org/10.1136/bmjopen-2018-021931

[lii] Neighbourhood Cares Pilot Report, December 2019. Cambridgeshire County Council.

[liii] Ibid.

[liv] Gray, B.; Sarnak, D.O.; Burgers, J. (2015) The Commonwealth Fund Case Study: "Home-care by self-governing Nursing Teams: The Netherlands' Buurtzorg Model. https://www.commonwealthfund.org/publications/case-study/2015/may/home-care-self-governing-nursing-teams-netherlands-buurtzorg-model

[lv] https://www.gov.uk/government/publications/uk-points-based-immigration-system-further-details-statement

[lvi] Cambridgeshire and Peterborough Clinical Commissioning Group, the BIG Conversation. 2019. https://www.cambridgeshireandpeterboroughccg.nhs.uk/get-involved/the-big-conversation/

[lvii] Government Recovery Strategy, 2020 p. 34.

[lvii] OfCOM data, provided by the Good Things Foundation, 2020.

[lix] Ibid.

[lx] Ofgem Connected Nations Summer Update 2020.