CAMBRIDGESHIRE & PETERBOROUGH COMBINED AUTHORITY | JAMES PALMER CAMBRIDGESHIRE & PETERBOROUGH MAYOR

19 January 2021

[redacted]

Dear [redacted]

Freedom of Information Act 2000 - Request reference CA102

With reference to your request for information received on 5 November 2020 and your subsequent clarification received on 15 December 2020 reference CA201, please find the response provided below. Please accept our apologies for the delay in responding.

Question

A summary of the appointment process in which Andy Wood was appointed to carry out the local govt. review.

Answer

At the Cambridgeshire and Peterborough Combined Authority Board meeting on 26 September 2018, Item 239 of the Minutes states the following:

> *'It was proposed to establish an independent Public Service Reform and Innovation Commission led by Andy Wood of Adnams PLC who would appoint his own members providing a good gender balance and the relevant expertise. Its first task would be to progress this project as set out in the terms of reference.'*
>
> *'It was resolved to: ……*
>
> *c) agree the establishment of an independent Public Service Reform and Innovation Commission which would support, inform and challenge the development of the Cambridgeshire and Peterborough health and social care proposition.*

For ease, I have attached a link to the agenda Document.ashx (cmis.uk.com) and minutes of the meeting Document.ashx (cmis.uk.com).

Question

A summary of contract between Andy Wood and CPCA.

The Mayor's Office
72 Market Street
Ely
Cambs
CB7 4LS

Answer

The terms of Dr Wood's appointment were set out in a letter from the Mayor dated 28 September 2018. A draft copy of the letter is attached – there was no record held of an issued version.

Dr Wood is the chair of an Independent Commission and is not an employee or contractor of the Cambridgeshire and Peterborough Combined Authority.

Question

The minutes of any meetings between Andy Wood and the CPCA.

Answer

Dr Wood attended two meetings with the Cambridgeshire and Peterborough Combined Authority Board members on 16 October 2019 and 11 November 2020. Extracts from the minutes are below:

11 November 2020

1.	Leaders to consider the report further and revert for further discussion
2.	Report to be informally shared with MPs

16 October 2019

1.	Commission invited to proceed with its work in line with interim report recommendations.
2.	Engagement programme to include a workshop with Leaders and appropriate officers.

Question

Any reports or notes produced by Andy Wood for the CPCA

Answer

The Commission has submitted two reports to the Cambridgeshire and Peterborough Combined Authority (Interim Report and Final Report). Both reports are attached.

Question

Any reasons for why the report has not been made public

The Mayor's Office
72 Market Street
Ely
Cambs
CB7 4LS

Answer

The Cambridgeshire and Peterborough Combined Authority is considering its response to Dr Wood's November report on Health and Care integration in the light of developing circumstances. Members of the Authority currently take the view that it would be sensible to consider further, including in particular awaiting a recovery from the current renewed Covid pandemic, before deciding a way forward on issues relating to the organisation of health and care services.

I hope this information is helpful but if you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review, you should write to us via our contact us email address – contactus@cambridgeshirepeterborough-ca.gov.uk or write a letter to Complaints, Cambridgeshire and Peterborough Cambridgeshire and Peterborough Combined Authority, the Mayor's Office, 72 Market Street, Ely, Cambs CB7 4LS within 40 days of the date of this e-mail.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, or via their website: https://ico.org.uk/

Generally, the ICO will not undertake a review or make a decision on a request until the internal review process has been completed.

Yours sincerely

[redacted]

Sue Hall
Governance Assistant

The Mayor's Office
72 Market Street
Ely
Cambs
CB7 4LS

CAMBRIDGESHIRE
& PETERBOROUGH
COMBINED AUTHORITY

Dr Andy Wood OBE DL
[redacted]

28 September 2018

Dear Andy

INDEPENDENT COMMISSION ON PUBLIC SERVICE REFORM IN CAMBRIDGESHIRE AND PETERBOROUGH

Thank you for agreeing to chair the Independent Commission on Public Service Reform in Cambridgeshire and Peterborough. The Devolution Deal which established the Mayoralty committed the holder of this office to consider ways of reshaping public services across a range of themes. My own electoral mandate is also founded on my pledge to improve the way the state serves citizens in Cambridgeshire and Peterborough, with a greater focus on people and places and a more effective use of taxpayers' money. I see the Commission as a vital support and source of advice as I take this important task forward.

The Combined Authority Board has endorsed the attached terms of reference for the Commission, including a structure for the Commission which we have agreed. I know that you have approached potential Commission members and I am writing to them today with a formal invitation to join. I understand that you plan to hold your first meeting as the Commission in the very near future.

I am very much looking forward to receiving the Commission's initial input on health and social care integration over the coming months, and also to seeing you and your fellow commissioners range more widely over the landscape of public service reform during next year. I would be grateful if you would consider producing an initial report on the broad scope for improving the way our local state works by the late Spring of 2019.

Once again I should express my gratitude to you for taking this task on, and wish you all the best for the success of your work.

Yours sincerely

Mayor James Palmer
Cambridgeshire and Peterborough

Incubator 2, First Floor,
Alconbury Weald Enterprise Campus,
Huntingdon, PE28 4WX

PUBLIC SERVICE REFORM & INNOVATION COMMISSION

1. Terms of Reference

1.1. It is proposed to establish an independent Public Service Reform and Innovation Commission reporting to the Mayor and the Combined Authority of Peterborough and Cambridgeshire.

1.2. The suggested terms of reference for the Commission are outlined below. It is proposed that the Commission will:

(a) Provide objective and independent advice and critical thinking on ways to make the public sector in Cambridgeshire and Peterborough more effective, responsive and financially sustainable for the future, and in particular to consider the scope for bringing services closer to the people and communities they serve in individual places;

(b) 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;

(c) 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;

(d) 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;

(e) Bring forward suggestions and recommendations about the levers that the Mayor and Combined Authority can influence to support delivery of the Commission's recommendations;

(f) Support the Combined Authority in making the case for public sector reform;

(g) 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;

(h) 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.

In the first instance, the Commission is invited to focus on supporting the Combined Authority's agreed programme of work on reform in the health and care sector during the autumn and winter 2018-19. The Commission is also invited to broaden its inquiry and report on the wider case for reform of the public sector in Cambridgeshire and Peterborough during 2019.

1.3. The initial membership of the Commission is:

(a) Independent Chair

(b) 4 independent directors

Supported by

(c) Senior level officer to act as executive director to support the work of the Commission.

CAMBRIDGESHIRE AND PETERBOROUGH INDEPENDENT COMMISSION FOR PUBLIC SERVICE REFORM

Interim Report

October 2019

Foreword

FROM THE CHAIR OF THE COMMISSION, DR ANDY WOOD OBE DL

The Cambridgeshire and Peterborough Independent Commission on Public Service Reform (CPICPSR) is pleased to publish the interim report. The Commission was established and is funded by the Cambridgeshire and Peterborough Combined Authority and has focussed on health and social care.

Our focus has been on how the Combined Authority and all its partners and stakeholders might best contribute to improving the health and wellbeing of the entire population that it exists to serve. Our conclusion is that this can only be achieved by looking to the wider determinants of health and wellbeing, particularly those not explicitly tied to healthcare, such as education, employment, development, transport, and planning. We hold to the principle that 'none of us is as smart as all of us'. Hence our intention that the vision and agenda contained in this interim report form the basis of a wide programme of consultation that brings together all of those involved - providers and users, professionals and volunteers, those working in health and social care, communities, local and central government – in the pursuit of a common objective.

The Commission which was formed in September 2018, has made great strides in understanding the environment, stakeholders, organisations, policies and other reports that have been produced or are being produced - this is to ensure that the report reflects all the available information that is relevant and useful, to avoid any duplication and to reduce costs. The views and opinions expressed in this Interim report are independent and the report has considered the Terms of Reference (Appendix).

I would like to thank all of those who agreed to be interviewed for the research element – their views, opinions and thoughts are reflected in this report. More than 20 interviews have been completed, the themes that have emerged have formed and framed this report, reflect the opportunities and challenges that need to be considered to ensure that this Interim report is comprehensive and is an accurate assessment of the environment. More interviews are planned in the upcoming months, and for those we have not yet spoken with, we look forward to doing so.

We have looked outside of the geographical boundaries of the region, to consider and review other ways of thinking about the issues that have been identified. To achieve improvements in people's health and well being there is a need for us all to strengthen our shared sense of responsibility across organisations, individuals, structures and our commitment to collective engagement and involvement. We are all dealing with a complicated tangle of the various organisations, strategies, lifecycles, budgets, responsibilities, governance, accountability and performance indicators. Moreover, as we observe in the report, there are huge differences in the major health challenges faced by people in different parts of the region. These differences need to be considered carefully if we are to create a firm foundation for shared progress.

In this way we can prepare the ground for a fuller final report, in which we hope to have developed further insights from a greater number of stakeholders. By then we would expect to better understand the opportunities for improvements in the health and wellbeing of the people of Cambridgeshire and Peterborough, whilst also demonstrating to other authorities the benefit of change and the development of a truly integrated health and social care system.

DR ANDY WOOD OBE DL

Contents

Executive Summary

The interim report sets out our conclusions and recommendations based on our work since the Commission was formed in September 2018. Our starting point is the health and wellbeing of the people of the Combined Authority. Our recommendations are in line with those of the Cambridgeshire and Peterborough Independent Economic Review (CPIER): an economically successful region cannot exist if the people aren't healthy, and healthcare costs are high and rising.

There is already work happening in our region to integrate health and social care approaches together, which should be supported and accelerated, but a lack of funding for healthcare and an illness-led approach is stifling change and limiting a long-term vision.

Large acute general hospitals play a vital role at the core of a modern healthcare system. They are good at what they do. By and large the problems they face is excess demand arriving at the front door and congestion in transferring patients out of care. These potential centres of excellence have a gravitational pull that is overwhelming the most costly part of the healthcare system.

The findings of this Commission to date are that agile, focused and well resourced community-based initiatives, well coordinated, offer an opportunity to bring about profound change at relatively modest cost compared to systemic change at the core of the system.

We advocate a Population Health approach - one that focuses on improving the health of the entire population of the Combined Authority region by looking to the wider determinants of health and wellbeing, particularly those not explicitly tied to healthcare, such as education, economic development, retailers, employers, transport, or planning. This relies on promoting a collective sense of responsibility across employers, institutions, individuals and structures, and on collective engagement and involvement.

The area covered by the Combined Authority is characterised by differences. We need solutions that recognise local differences and build on local and community assets and strengths.

There are examples of excellence, within the region and elsewhere, on which we can build, and that should be accelerated. These include:

- 'Blue Zones' - areas where healthy living is designed-in through town planning, engaging schools, workplaces, restaurants, food suppliers, community groups and others, to promote healthy eating, exercise, and mental wellbeing.
- Social prescribing, the role of primary care networks, Integrated Neighbourhood approaches and other approaches to localising and integrating health and social care
- New models of caring, such as Buurtzorg-type models and Neighbourhood Cares are currently being trialled in the region
- Employer engagement on health and wellbeing, of which Anglian Water is a national leader, and public services employers should be leading the way
- Public services collaboration, such as the local approach to homelessness in Peterborough, which is led by housing but with policing, drug and alcohol unit, voluntary sector and GPs

The ambition of the Combined Authority can be to move towards a truly integrated health and social care system, including but not limited to the role of Primary Care Networks, the North and South Alliance, Integrated Neighbourhoods, the Public Services Board, the Clinical Commissioning Group (CCG), the The Sustainability and Transformational Partnership (STP) and others. To move this forward the various bodies responsible need to work together to develop this vision and start to initiate change. This will involve mapping out the region to outline the changes that may be needed in organisational structures while showing strong local understanding when approaching health and wellbeing. The priorities for action in parts of the Fenlands will differ from those in central Cambridge and these will differ again within different parts of Cambridge and compared with Peterborough.

Our continuing criteria for decisions need to be the economic and wellbeing outcomes from these local changes. The right outcomes will only be achieved with the involvement of providers and users, professionals and volunteers, elected representatives locally, regionally and nationally.

It is our intention that the vision and agenda contained in this interim report form the basis of a wide programme of consultation that brings together all of those involved - providers and users, professionals and volunteers, those working in health and social care, communities, local authorities and central government, voluntary sector, local employers and front line workers and users of services – in the pursuit of a common objective for the health and wellbeing of the region.

A formal devolution settlement could accelerate these changes. Such an approach supports better democratic accountability. It does so by moving health 'down' from a national level and moving social care 'up' from the local government level, and placing the budgetary constraints within the power of a democratically elected body. As the Commission we believe that the closer we can get democratic accountability to the delivery of services, the more person-centred the health approach will be. A t the same time there are financial drivers for change, and if a devolved settlement can help to alleviate some of the financial pressures this will be a significant driver for doing so.

The Vision: Why is health a priority?

" The current health and social care system is under immense pressure, and operates as a 'diagnose and treat' system, not a health system. This is unsustainable. We believe in a better future for the Combined Authority area. Where the entire functioning system is set up to promote the health of the people."

Imagine revisiting this region in ten years time, and discovering that, as a result of a fresh and collaborative approach across all the usual boundaries:

- Healthy eating has spread across the region, with reductions in obesity and related illnesses and referrals to primary and secondary care.
- Better transport planning has reduced pressure on specialist facilities for respiratory and related conditions, and rates of asthma.
- Our older people are more healthy and a long healthspan becomes the norm, as opposed to years of gradual decline.
- Local employers have developed and committed to wellbeing strategies for their workforce.
- The region has the most motivated and healthy workforce in the UK, and that leads to increased productivity and a boosted economy
- Care for the elderly and dependent citizens in their homes is being provided by well-trained, empowered care workers operating under a Buurtzorg model of provision. This has reduced DTOCs, and offers a more effective early warning of falls and other risks before they fully materialise as emergencies. This reduces pressure on the ambulance service.
- New housing developments are only permitted where they meet the CA's minimum requirements on population health. Developers have committed to setting development goals that are linked to the health and wellbeing of residents .
- A growing number of social services users have become involved as contributors to wellbeing, through the influence of initiatives such as neighbourhood cares and social prescribing. Pressure on GP time is reduced. The longer-term payback from these pilots is encouraging authorities to go further in extending them, confident of their viability.
- The damage to health and wellbeing caused by extreme weather, flooding, heatwaves and other climate-related risks has begun to be mitigated, reducing the pressure on emergency services.
- When people are ill or in need of care, the care they receive is people-focused, particularly for those with complex needs or co-morbidity of illness

The Combined Authority area has the potential to be one of the most thriving in England. It has leading businesses, Universities and Colleges, is a centre for innovation both for knowledge-intensive industries, and traditional and agricultural business. It contains some of the most significant companies and Institutions in the country. Health is essential to realising this ambition and will underpin the area being a world leader. A successful region cannot exist if the people aren't healthy, and the health of the people cannot be achieved solely by the current health and social care system.

The vision we want to work towards is simple: where the people who live in this region are physically and mentally healthy, and that those who are ill or in need of care can get the care that they need.

This Commission supports and builds on the recommendations that the Cambridge and Peterborough Independent Economic Review (CPIER) have already outlined about the economic future of Cambridge and Peterborough. As they note, and we echo, "the health and well-being of individuals, along with their education and skills, are central to a flourishing economy".[1]

A flourishing economy, where the economic benefits of health are realised: in a system where people are healthy, they are also productive and prosperous. Businesses are attracted to the region and the economic benefits are felt throughout. Improving health and well-being will also lead to the reduction of health inequalities, which in turn leads to improved productivity, greater economic participation and lower welfare costs and, again, reductions in health care costs. A systematic approach to health will lead to gains that run deeper and are more long lasting than restricting budgets and services.

This vision is realistic. It is economically and financially prudent and, in the longer term more practical than any alternative. It is based on the assets we already have and the work already happening. It is also necessary to make change; this is a call to arms. Our region is facing significant future challenges that, if not addressed, will be at the detriment to the health of the people, the economic health of the region, and its prosperity. It will be a wasted opportunity if we do not address these issues.

This report focuses on the role of the Combined Authority in delivering this vision of the health and wellbeing of the region. It can play a vital role in planning for health, taking a long-term transformative rather than a short-term transactional approach, and in doing so can support the valuable work already occurring in the region to better integrate the health and social care system, much of which is still in its infancy. The Combined Authority is well placed to support this work, to accelerate it, and to take a leadership role by placing health at the centre of decision making.

It should encourage citizens to be the "architects of their own health". In doing so, it will contribute to a region being prosperous and productive.

1.1 PRESSURE ON OUR HEALTHCARE SYSTEM

Greater demand; less money

As a region, we simply cannot afford to do nothing. As a result of national trends and local funding constraints, we have a health and social care system that is under considerable strain. This is leading to short term thinking and narrow decision making, and difficulties collaborating across organisations.[2]

This pressure is felt across the UK. The demand of NHS services and the cost of their delivery has grown faster in relation to the growth of funding.[3] "As a system the collective financial forecast for 2018/19 is an NHS deficit of £134m, a £39m deterioration against the 2017/8 year-end performance and inclusive of £55m sustainability and transformation funding" [4] The current government has pledged to increase NHS funding by circa £20bn a year by 2022/3. However, for the budget increases to meet the needs of the declining state of health and demographic changes, an additional £3.2 billion per year would be needed to maintain an adequate quality of care.[5] Estimates by the Health Foundation suggest that in real terms, the funding of public health has decreased by £700 million between 2014/5 and 2019/20.

The Cambridge and Peterborough Clinical Commissioning Group (CCG) is one of the largest in England by patient population and is also one of the most financially challenged in the country. By some reports this constitutes a 'time of crisis'. The CCG is committed to making major savings and cuts – a savings plan of £32.7m to hit its £75m deficit target. These cuts, although necessary, result in short-term cuts to services that may represent part of the long-term solutions to the problems of the area.

This deficit originates, in part, from a funding formula that under-estimates the local population. As one of our interviewees put it: "Put simply, the formula for the cash is wrong". The nationally calculated population forecasts predict that by 2026 there will be around 900,000 people in Cambridgeshire and Peterborough, while locally calculated forecasts predict it will be closer to 990,000 people.

1.2 DEMOGRAPHIC CHANGES

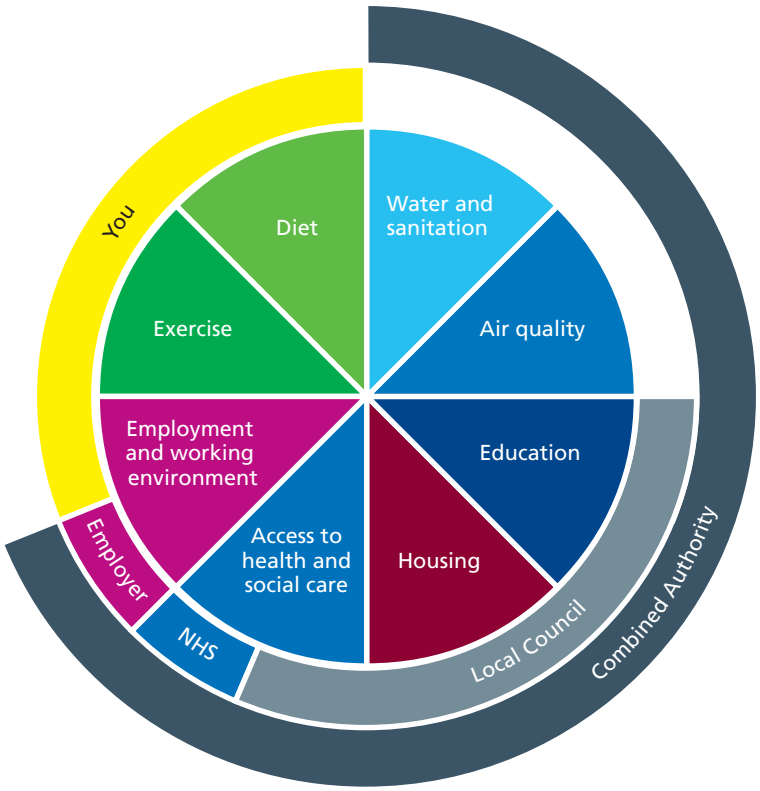
Older people; fewer resources

As a nation and a region, we have an increasing population and an ageing population. Population growth is predicted to be higher in the Combined Authority than in the population more generally,[6] and one which is ageing faster. This increases demand for healthcare while lowering tax income. The number of people in Cambridgeshire and Peterborough aged seventy-five or over is expected to increase by between 40% and 50% from 2016 to 2026.[7] The risk that a local resident aged 75 or over will be admitted to hospital as an emergency increased between 2012/3 and 2017/8 in all parts of the region, and is particularly notable in certain areas, such as Fenland and Peterborough.

Other broader societal changes make a difference to our health and how we care for each other. The proportion of women in employment, having reached an all-time high of 71.4% in 2018[8] impacts on the informal care system: as women have more traditionally taken care of informal, unpaid care, their shift towards employment poses a reduction in unpaid carers. This necessitates an increase in staff into the formal care systems and raises concern over the affordability and quality of localised care.

The proportion of single-person households is also estimated to increase to over 10 million by 2039. When people increasingly lack proximate companion (and children) to care and assist in the old age, more reliance is placed on the public care system and wider community. Estimates pose that by 2033/4 the national spending on healthcare would have to be raised by 1.6% to retain the current level of service, and to improve areas that are currently underfunded (such as mental health), the spending would need to be increased by 2.6%.[9]

WHO IS RESPONSIBLE FOR YOUR HEALTH?



1.3 HEALTH IS NOT JUST ABOUT HEALTHCARE

Health over illness

The NHS five-year review notes outlines that the best course of action to address this pressure on healthcare for the future is a radical upgrade in prevention and public health.[10] Our spending as a nation on health and social care is concentrated in a health system which, as important as it is, is responsible for a relatively small proportion of health outcomes. It is an 'illness' system, as opposed to a health system. Furthermore, the provision of healthcare - either through primary care, secondary care or through social care provision, is just one aspect of that which drives the health of a population.

1.4 PREVENTION AND POPULATION HEALTH

Architects of our own health

It is increasingly agreed that much of the growing pressure on the NHS can be alleviated by looking at the societal reasons for ill health – that is, moving from treating the sick to preventing them from getting sick in the first place.

Among the UK population, there are many well-known health risk factors that are ripe for intervention. Seven out of ten adults do not meet the Government guidelines on daily healthy behaviours that reduce the risk of diseases such as cancer, heart disease, diabetes and premature death. This broad majority regularly practices two or more of the following risk behaviours: poor diet, physical inactivity, excessive alcohol consumption, and smoking.[11] Estimates hold that around a third of children in the UK, ages 2-15 are overweight or obese.

The 2019 NHS Long Term Plan outlines a framework for this: Population Health Management (PHM), an approach that identifies at-risk patients and addresses the preventable issues affecting them. This data-driven system works by "grouping populations according to their conditions, severity of illness, demographic qualities, or other parameters, to identify risk levels".[12] This allows preventative resources, such as education, consultation or wellbeing programmes, to be directed towards higher-risk groups.

This is not always simple. It relies on individuals' voluntary self-care, which as a preventative solution will inevitably do more to help people who are already motivated and able to change their lifestyles and may exacerbate inequalities; it is only a partial solution. People subjected to interlinked forms of deprivation, such as poverty and unemployment, are often in relatively poor health both physically and mentally. The reasons are many, among them the relatively higher price of a healthy diet, the additional costs of health-maintaining activities, and the impact of detrimental ways of coping with deprivation-related stress, such as smoking and alcohol. These individual and structural issues often have intergenerational roots and consequences, and need measures beyond health education to tackle them at the level of cause rather than effect.

Some improvements have been made, with the introduction of highly visible campaigns along with legislation that steers or "nudges" consumer behaviour, such as the smoking ban,[14 15 16] and the 'sugar tax'. While public opinion on consumer regulation is not unanimous, the majority support a minimum unit price on alcohol and reducing children's access to and exposure to fast food.[17]

1.5 POPULATION HEALTH

Wellbeing and good health for all

Population health takes the principles and approach of public health one step further, focusing 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. This means prioritising the wider determinants of health and wellbeing. Crucially, many of these determinants, such as education or planning, are not part of what is usually considered healthcare. It means organisations and individuals across various domains accepting a degree of collective responsibility for protecting and promoting health and wellbeing; it also means making a priority of reducing inequalities in health, as well as improving overall wellbeing and reducing pressure on services.

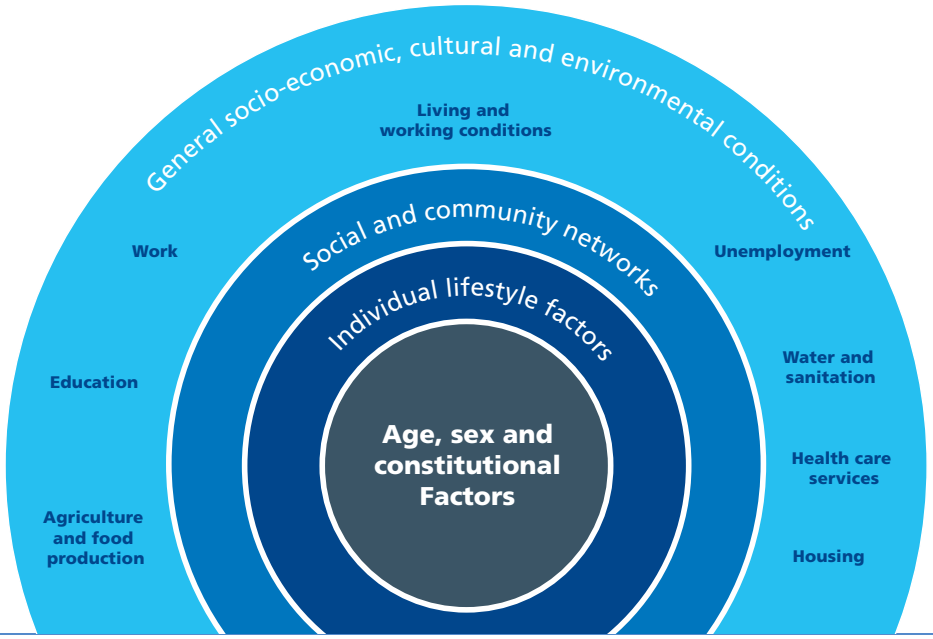
This kind of perspective could be hugely beneficial to the Combined Authority, recalibrating our focus towards the wider socio-economic drivers for health and wellbeing and pushing us to take into account the area's established inequalities.

To map out what this would mean in practice, below is the King's Fund's schematic outline of the determinants of health. In the outer circle (most fundamental) are agriculture and food production, education, work, living and working conditions, unemployment, water and sanitation, health care services, housing. Inside the next circle, inward are social and community networks, and inside that individual lifestyle factors. At the centre are age, sex and constitutional factors.

The King's Fund explain that a population health approach demands a strategy covering four "pillars": the wider determinants of health; our health behaviours and lifestyles; an integrated health and care system; and the places and communities we live in and with. These four categories overlap and intersect.

To plan and implement such an approach, we need to see change at a national, regional and local level. At a national level, the Government and NHS are already coming around to focusing on prevention as well as treating illness. At a regional level, population health could be achieved through devolved healthcare budgets, STPs, and integrated care systems. At a local level, we see change occurring within individual cities, towns and neighbourhoods. In many ways, this is already happening in pockets at the local level and at the regional level, but there are still many opportunities for the Combined Authority to contribute.

THE KING'S FUND: A VISION FOR POPULATION HEALTH



1.6 DIALLING UP AND DIALLING DOWN

The region is in many ways a microcosm of the UK: alongside success, there is significant spatial inequality. Each part of the region faces their own challenges in terms of health outcomes, but they also have strengths and local assets. Inequalities can be addressed by taking a whole-region, holistic view that seeks to address the shortages of one area from other areas in the region. The region has huge assets that can be drawn upon.

As the CPIER report outlines: *"It is not one unified economy but three quite different ones. The south of the area, the "Greater Cambridge" area (which takes in Cambridge, South Cambridgeshire, and parts of Huntingdonshire and East Cambridgeshire), while not without deprivation, is prosperous and attracts many international businesses to come to the area and grow. Skills levels and wages are high. Secondly, to the north around Peterborough, there is much industry and potential; however, deprivation levels are higher, and many residents feel untouched by the economic success of the Greater Cambridge area. This is also true in the agricultural areas and market towns that make up the third area, broadly defined as the fens."* [18]

There is a huge amount of data already being collected in the region that can give us a picture of what is needed in each area and what strengths there are in each area. Indicators and wider determinants of health and wellbeing in CPIER for instance highlight the density of fast food outlets (lower than the English average in Cambs and Hunts), Employment rates and economic activity (higher than average in Cambs), number of unpaid carers (higher percentage in Fenland than across England), low income; children in low income households; violent crimes (higher

all in Peterborough) and educational attainment (lower in Fenland).[19]

Cambridgeshire as a whole has the lowest rates of teenage pregnancy in East of England, and a higher rate of breastfeeding at 6-8 weeks than the national average (56.1%). All Cambridgeshire districts fall below the national average for childhood obesity (17-18% vs. 22%). 87.1% of Cambridgeshire children are free from tooth decay, better than the national average and the highest in East of England.

In terms of healthcare however, there is a "doughnut effect" where access to health services is limited in areas that are geographically closer to some services than others. Within Cambridgeshire, there are places only 10 miles apart with a 10-year difference in life expectancy.

These discrepancies are visibly patterned across the Combined Authority region. Where Huntingdonshire and East Cambridgeshire score fairly well on various indicators, Peterborough and Fenland score significantly worse than several English averages. Both districts have the worst determinants of health and well-being in the Combined Authority; this is related to other measures of social inequality, such as educational outcomes, rates of homelessness and poverty.

While Cambridgeshire children overall achieve a similar level of "school readiness" at 4-5 as the national average, those eligible for free school meals achieve far worse results. Poor school readiness and educational disadvantage may be driving serious long-term health and other inequalities in the region.

These disadvantages are not limited to children. As the CPIER identified, levels of disability and general ill health are generally low in Cambridgeshire but are higher in Peterborough and also the Cambridgeshire district of Fenland.

While nearly two-thirds of Cambridgeshire and Peterborough adults carry excess weight, East Cambridgeshire and Fenland Districts have levels above the national average. While obesity levels across the region are generally lower than the England 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 while Fenland has a high level of smokers.

Even in relatively affluent Cambridge, though, the picture is still mixed. South Cambridgeshire has the best profile in relation to wider determinants of health and well-being.[21] and the most common cause of years of life lost due to premature death, followed by stroke, chronic lung disease, dementia and self-harm. At the same time, in areas where we see the highest levels of employment in fast paced, high pressure industries, we see high rates of burnout, anxiety, and stress. In these areas it is also more important to look at how the elderly care system functions, and to provide extra support to adults of working age who may be more likely to be caring for elderly parents or relatives. [22]

Overall, the Combined Authority is characterised by differences. We need structural solutions that recognise local differences and build on local and community assets and strengths. The Public Health strategy in the region has already recommended that health and wellbeing indicators be mapped at the local level to help "fine tune" provision, 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. There is also work being done by local and neighbourhood approaches, and by primary care networks, to approach this on a local level with regards to health and social care provision. From a Combined Authority perspective, this can support a holistic view that focuses on how the individual can be an architect of their own health.

We need to adopt a policy for population health which acknowledges these "opportunity areas" and to generate specific policy interventions that take a broad view of health. We do not reproduce all the information here, but recommend that this data and others be identified. This includes for example: socio-demographic data, education rates, deprivation, hospital attendance rates, transport, crime statistics, income and employment data, disability rates, smoking rates. It can and should also include local expertise from health care providers and leaders, organisations such as Healthwatch, employers, charities, which all help to map local assets and needs, through the lens of health.

Realising the vision

Our vision is not far-fetched. There are examples of good and best practise where this is already happening, within the region and elsewhere and of well-known concepts and models that show potential for adaptation and trialling on the ground.

2.1 PUBLIC SERVICES: REFORM AND INTEGRATION

"There is already work happening to integrate approaches together, and to make health and social care more locally-driven, more patient-led, and more focused on prevention and less on cure. "

Addressing the issues, we have in the system currently and working towards a vision of the health of the region means supporting the current work being done by people in the public services to address health. There needs to be an acknowledgement of what is already happening and for the Combined Authority to play a role in bringing these approaches together and encourage them to continue.

This includes approaches by the Clinical Commissioning Group (CCG), the Sustainable Transformation Partnership (STP), an Integrated Commissioning System, Public Services Board, Health and Wellbeing Board, and a Think Communities approach, North and South Alliances; an Integrated Neighbourhood work stream; Primary Care Networks; Neighbourhood Cares and an Adults Positive Challenge Programme. We expand on these below, drawing on our interviews with stakeholders in these various programmes.

Public Services Board

The Public Services Board and the Director of Public Health are integrating approaches, focusing on the 'Grand Challenges' that are facing public services, and making recommendations for how they can better work together. This provides a kind of brokerage space to talk through collectively, monthly meetings across public services, to discuss, support and challenges, and to share best practice. There is work going on to ensure that the public health approach and strategy is in line with the public services board's grand challenges.

Primary Care Networks and Integrated Neighbourhood teams

The NHS both locally and nationally is developing Primary Care Networks, based on groups of GP practices covering about 30,000-50,000 people. In Cambridgeshire and Peterborough, community health services and adult social care are creating Integrated Neighbourhood teams around these GP practice groups – aiming to build local relationships and 'joined up' care.

The success of these PCNs rests on surmounting a number of issues, including the staffing issues GPs are facing; a lack of collaborative culture, and a lack of the right organisational skills and resources within the GP surgeries. It has not been without its challenges, and there have been some issues with PCNs being halted because GP surgeries are reluctant to collaborate with the others in its local areas. The PCN concept works best where the GP practice already holds a strong place within a community or has already done a great deal of neighbourhood engagement, and where the Local Authority is able to wrap provisions around the surgeries.

These PCNs are also supported by an increased focus on Social Prescribing. This helps the GPs to link the community assets. This could also be supported further by looking into technological innovation, perhaps through the development of a regional directory of services, that could support the link workers and the Primary Care Networks. It would also help to empower the end users and take the pressure off the GPs as the key hub for service provision.

Think Communities

Public sector bodies across the Combined Authority are increasingly working together using a Think Communities approach, promoting public health and tackle the key determinants of health and health and social outcomes. Think Communities has been endorsed as an approach underpinning public service reform by the Cambridgeshire and Peterborough Public Service Board. This takes a "People, Places and Systems" approach to building relationships and supporting communities to be strong, connected and responsive. This means having an understanding that no two local communities are exactly the same, and the health needs, skills and assets within different communities will vary widely. It also means moving out into the community, to have communities, to get staff closer to people.

The Think Communities principles provide a framework which will support and/ or drive a number of different strands of activity across the public sector, both nationally mandated and local. The approach will:

- Help communities to support themselves, encouraging community-led solutions and interventions. (People)
- Work with communities to harness and develop their skills, experience, knowledge and passion targeted towards those in the community requiring the most help. (Places)
- Support active, healthy communities to play a clear and evidenced role in improving people's lives, thereby preventing, reducing or delaying the need for more intrusive and costly public services. (Places)

- Arrange resources to create multi-agency support which can flexibly meet the changing needs of our communities. (Systems)
- Be willing to be experimental in our approach, in order to deliver individual local solutions and support ideas that can be replicated. (Systems)

The transformation programmes taking place across the health and social care system embody these principles, and are already demonstrating the impact a Think Communities approach can have.

To support the delivery of this work, Cambridgeshire and Peterborough Public Services Board have agreed to look at how the governance arrangements which will drive the Think Communities approach can be strengthened and/ or aligned to existing arrangements. This will include the creation of an 'Executive' board comprised of senior officers from partner organisations. This will be underpinned by a number of District/City Place Based Delivery Boards, according to the needs and circumstances of each District/City. This will mean that the way the governance for Think Communities is taken forward at a District/City level is likely to vary and may work to different timescales, but the driving principles take all the partners forward in the same strategic direction.

In addition to creating the right governance arrangements, key strands of work include building a multi-agency data set at Lower Super Output Area, which will give a 360 degree overview of the demographics and local need within small communities. A workforce transformation programme is also being developed, which will ensure that staff are ready and able to deliver a new way of working.

A North and South Alliance

A North and South Alliance have been established to work together at a neighbourhood level, around our acute hospital footprints with providers of services for health and social care working together on a partnership basis to provide a wider range of services across a geographical area. The goal is to deliver more proactive, person-centred and holistic care to local people, pooling resources and budgets where it will add value. Each Alliance has an Integrated Neighbourhood work stream which is overseen by partners from the NHS, Local Authorities, Healthwatch and the voluntary and community sector. Integrated Neighbourhood Managers have been appointed and the work is starting on the ground building multi-disciplinary teams around the PCN geography. This will be supported by the Think Communities work through detailed profiles of need and by bringing together a wider range of public and voluntary sector partners to tackle the wider determinants of health. This pulls together data from a number of sources to identify localised need, including demographic data and healthcare needs.

Challenges being faced by integrated approaches

There is talk of an integrated approach and a great deal of good work being done. Our interviews suggested that we are on the cusp of these things being brought together well - and this hope and optimism should be harnessed and accelerated.

For this to work well, it must be built up from local pools of excellence and occur within a system-wide culture of learning, to help to translate success from one discrete 'pool' to another. Some of our conversations identified a resistance from all sides to learning from each other, and defensiveness. We know that pockets of good practice exist. But these are often led or limited to one individual or organisation, not system-wide.

Although it is better integrated, it was flagged by many that the CCG, STP and Local Authority prioritise their own part of the integrated approach. As one interviewee put it, "I support integration, but health and social care have different views of what that means." When we talked with Jon Rouse, Chief Officer for Greater Manchester Health and Social Care Partnership, about his experience with Greater Manchester's devolved health and social care system, he had found this too: that if there is no big picture vision to empower the various groups, they will ultimately revert back to the organisations or systems they work for. There is a sense of fiduciary duty to their own that is pervasive, and is inbuilt in the system, and this encourages transactional thinking, not transformational.

OTHER LOCAL EXAMPLES

Peterborough approach to homelessness

In Peterborough there is a Rough Sleepers Task and Targeting group that is run and managed by Housing in Peterborough. This 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, voluntary sector and others) in monthly meetings to discuss specific cases and put together support and solutions that are specific and relevant to individuals. This also collaborates with the local voluntary sector, including The Garden House, a church-based charity that provides services to homeless people in Peterborough. We spoke with one of the members of this group, who told us that part of the success of this approach lies in how it encourages collaboration, shared decision making and face to face communication. The success of these collaborations rests on shared decision making and communications, building plans together and shared responsibility and shared risk. Face to face engagement also makes a real difference as it gives the groups the opportunity to be more flexible with services, treatment criteria and make decisions that are in the best interests of the end user.

Reducing DTOCs

One of the key problems identified by the NHS five-year plan and others is the Delayed Transfer of Care (DTOC). This is a delay in discharging inpatients who are ready to go home, but for whom the services necessary for post-discharge care and support are not yet ready or available.

DTOCs often occur when other services are delayed – when patients are waiting for a home care package, a place in a non-acute care unit (e.g. rehabilitation or nursing home), or an assessment at a non-hospital unit or at home. Measuring, understanding and eliminating DTOCs should be a priority both for financial reasons and for quality of care. It is a waste of resources for people to spend time in units whose care they no longer need, supported by resources needed for other patients. When DTOCs mean beds are unnecessarily occupied, the result is "traffic", where patients are backed up into acute and emergency departments which cannot transfer them out due to lack of space.

The monitoring of DTOCs in this region has resulted in a reduction, and further headway is being made as authorities work to understand the organisational problems that allow them to occur. Many of these are not structural or financial, but practical. As one of our interviewees told us:

"We've had the highest rate of DTOCs in the country for years. And every year we put in investment trying to solve this problem. We found that the problem wasn't at the top – the leaders were saying all the right things. But the barriers to change were right at the bottom, with the people who were dealing with the patients. They hadn't been included in all the changes or trained in it. So, we have cracked it this time, because we have involved the practitioners in the change, got them involved in how to make the change. You need the will and the way, you need the investment, and you need the training. That success comes from joint working without a doubt."

2.2 ENGAGING EMPLOYERS

Work plays a central role in our lives, and can be a major source of wellbeing, or can be detrimental to health. There is a major opportunity here for transformative change. We also know that people's health outcomes are closely linked to educational outcomes, employment, and the type of jobs people have.

This may particularly an issue for certain areas: better quality jobs and upskilling can lead to better health outcomes. Those people out of work as a result of health issues that can be supported back into work should be. This is a particular issue in areas where there is a high proportion of people on benefits because of mental health issues.

The CPIER's final report outlined a specific recommendation on workplace health which this Commission echo: "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. These are likely to include the nature of workplaces, monitoring of health, and work flexibility." [25]

Government agencies are now embracing this idea. In recent guidelines, Public Health England writes that good quality work improves the wellbeing of individuals, their families and communities, both directly and indirectly. Aside from immediate work-related illness, it also "protects against social exclusion through the provision of income, social interaction, a core role, and identity and purpose". These are known to be fundamental determinants of good mental and physical health.[26]

Given how much of their lives people spend at work and the amount of contact they have with their employers, the workplace presents some of the best opportunities there are for innovative wellbeing interventions. The employee-employer relationship can be the most consistent, transparent and dependable relationships a person has with any responsible institution in their lives, and from an employer's perspective, anything that improves workers' overall wellbeing can pay sustained dividends.

As is argued in Dame Carol Black's review, 'Working for a healthier tomorrow: work and health in Britain' "Health should be reflected in all employment policies, fully exploiting the synergies between the health, employment and skills agendas." [27] Dame Black also argues that occupational health needs to include more than simple clinical treatment of health matters, and must be more inclusive of those outside employment.

Reducing the rate of unemployment in any given area – whether through health initiatives or through wider ways of addressing unemployment – can have a cyclical, positive relationship with health outcomes. As the CPIER report noted: "If the rate of Employment Support Allowance (ESA – the benefit claimed by those unable to work through ill-health or disability) claimants in Fenland and Peterborough (6.9%) were similar to England average (5.7%) there would be 2208 fewer people on ESA and in work. The economic value of a resident moving from ESA to employment is estimated to be £13,000 per year and this would therefore provide an economic boost to the Cambridgeshire and Peterborough economy of £29 million per year. This figure alone is some 50% greater each year than the investment fund secured by the Combined Authority as part of its devolution deal." [28]

Health also affects, and is affected by, skill and employment level: unskilled working-age people experience three times as many health issues as workers in professional sectors, and while income has an impact on health, being in good health also enhances earnings potential. Improved health therefore helps bring down turnover rates and improve the workforce skill levels, in turn reducing recruitment and retraining costs.

One area where this is somewhat trickier is in the area of zero-hours contracts and casual, seasonal and/or insecure employment. The area is host to certain industries (e.g. some agricultural work) whose employment patterns do not include sustained personal contact with line managers equipped to "look out for" employees above the most basic level. This is an area where the upskilling of the local population clearly has a role to play, as more secure, better-paid jobs that offer the possibility of progression can improve employees' mental health prospects – and indeed, often their physical health prospects too.

Work and mental health

Since Dame Black's report was first published, the concept of "workplace wellbeing" (as opposed to the narrower "occupational health") has become more prominent, particularly in relation to mental health. Since the publication of the Stevenson-Farmer review,[29] the idea that employers both can and should protect their employees' psychological wellbeing has been elevated to the top of the agenda. Analysis by Deloitte[30] has started to find evidence for how investing in mental health at work is good for business and productivity. Employers are increasingly aware of their responsibilities for promoting health and wellbeing, moving away from a purely risk-based analysis and into a proactive, prevention approach that harnesses the value of this for the business.

Mental health problems are among the most common health risks among the general population, with as many as one in four people affected every year. Workplace wellbeing has become a key issue for many businesses, and indeed, there's now a booming industry of wellbeing and mental health "providers" for employers.

While much has been done to eliminate the stigma around mental health issues – work that continues today – less has been done to find rigorous, research-backed ways to prevent mental health issues from arising in the first place, both in and out of the workplace. This is partly because the sheer number of available interventions makes comparative evaluation impractical; another reason is that many of the tools and guidelines businesses are using are relatively new, meaning the evidence base is simply not yet there to draw upon. However, given that plenty of employers are keen to roll out mental health strategies, some on a very large scale, they are rapidly becoming a valuable source of data on wellbeing. In some cases, they are also developing specific expertise. A future, collaborative or integrated view of health and social care could start to include this. It may soon be considered a priority to encourage workplaces to share their insights, their good practice, and the data they collect on their employees, with the local health and social care systems. Such an approach could also encourage more collaborative working, rather than a sense within workplaces that they are "taking on the job of the healthcare system".[31]

Employers can also be better engaged as part of a whole health-centred approach to people. One area for example is thorough better provisions for those with caring responsibilities. While employers are legally required to provide maternity leave and, latterly, paternity leave, it is more common for working age adults now to be caring for parents or elderly relatives. Some of the more forward thinking employers are accounting for this, with carers leave and flexible working.[32]

Local pools of excellence

The region hosts some major employers who could be engaged on this front. Anglian Water have won numerous accolades for their work on employee wellbeing; in 2018, they were named Glassdoor's best place to work,[33] and in 2019, they won Business in the Community's Bupa Health and Wellbeing Award. This is the result of a process the company began in 2005, when, in part to reduce the cost of medical cover and sickness days, they decided to focus specifically on improving employees' wellbeing. The results were clear: for every £1 spent on wellbeing initiatives, they saw an £8 return in these savings, as well as a notable reduction in workplace accidents. This has since led to them broadening their focus to nutrition, mental health and financial wellbeing. Working in partnership with GlaxoSmithKline, they have also developed a "wellbeing calculator" that tracks shift in spending from reactive to proactive and demonstrates the savings they have made.[34]

There is already appetite to further the local work on wellbeing in workplaces, being led by Dame Carol Black and others, including RAND and Public Health England. Taking this forward could also include engaging business networking sessions such as the Chambers of Commerce, Opportunity Peterborough and Cambridge Business, the CBI, and the Chartered Institute of Personnel and Development (CIPD) local meetings. It could also be explored how businesses' CSR initiatives could involve employees in health care and prevention. Public sector employers can also be engaged in this, as expanded below.

2.3 EMPLOYMENT IN HEALTH AND SOCIAL CARE

Many of the major employers in the region are the health and social care providers themselves. We know there is a problem with recruitment and retention in the healthcare system that has to be addressed. But there is also an opportunity to support the public and population health agenda through focusing on the training and retention of nurses, carers and volunteers. This could also help to meet other goals of reducing unemployment.

Nationally, there is an ongoing problem with the retention and recruitment of staff in healthcare. As the number of students training to become nurses has experienced a sharp fall, the NHS Long Term Plan has ruled international recruitment as a necessary component to alleviate the shortage of staff. However, the uncertainty of Brexit and migration policies has put the plans to increase international recruitment to a halt. Voluntary immigration from the EU area has decreased as the impact of Brexit on the migrant status is unclear.[35] The staff retention rates of the NHS have also shown a consistently worsening performance since 2011-12. There have been policies put into place to facilitate the employment of students and increase retention. In some areas however, this has unwanted effects: the recruitment of nurses has partially come at the cost of decreasing amount of social care workers, increasing pressures elsewhere in the system. The aspiration to increase the number of GPs also remains an issue. Seven out of ten GPs are considering one or more of the following: leaving patient care, taking a career break, or reducing their hours.[36]

This is a challenge, but one that could be addressed through a focused effort on recruitment and retention across the health and social care system. New models of care, such as the Buurtzorg model discussed below, find better carer job satisfaction. This also helps to localise care, which is a primary objective for making pilots more successful.

We therefore recommend that the CA develops a linked focus on vocational training in the region. Care providers, education and training institutions, and local authorities can all play their part in ensuring that care becomes a source of high-quality employment, and a source of improved quality of life for those who need care. There needs to be training available which makes access to a respected and fulfilling job in social care available to many in the region. At the same time there needs to be encouragement and experimentation that brings further examples of social work and care and community nursing. The CA could play a key part in being a catalyst for these developments. The double benefit would-be better-quality care for those who need it, and better-quality jobs for those who need them.

This will need further work. It was noted by one contributor from setting up Hospice at Home in Wisbech and Fenland, that while they assumed there would be many applicants for the role, it was difficult to recruit. Similarly it was found with the Neighbourhood Cares pilot that while the pilot was successful, it had not yet led to changes in terms of local recruitment - care was still coming from people travelling in to the area.

Public services are employers themselves and could be an ideal starting point for employee wellbeing. More work must be done to make these employers more engaged in the wellbeing of their employees - building health and wellbeing from within. CPIER provide a case study that was successful in Cornwall [37] and that could be replicated in this region.

2.4 PROMOTING NUTRITION AND EXERCISE - A 'BLUE ZONE'

Since nutrition and exercise are at the root of overall health, a fundamental determinant of our health is the area in which we live. In certain places around the world, longevity is part of the way of life thanks simply to how people live their lives; these places have been termed "Blue Zones". The "discoverers" of Blue Zones developed an idea about the promotion of public health: that rather than focusing on changing individual behaviour, an area or community must be changed to make it easier to nudge its residents into exercising and eating well.

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 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 where people spend their time. 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. This too can be encouraged and supported across workplaces, schools and the voluntary sector.

Since the idea of Blue Zones has been identified, efforts have been made to create artificial ones in US towns. These initiatives required strong and civic leadership, in most cases from a mayor, but also support from the private sector.

Towns that experimented with Blue Zone design set about re-designing work and lifestyle opportunities to subtly change people's everyday experiences, "nudging" them towards marginally better health decisions across different domains. This included changing municipal policies on trading and planning so that fruit and vegetables are favoured over junk food, pedestrians over cars, non-smokers over smokers, and so on. These towns created a "Blue Zone certification" for shops, restaurants, schools and workplaces, who could also take a "Blue Zone pledge" to reshape social networks and activities within their organisations to promote healthier environments, diets and increased movement.

Many Blue Zone pilots have been highly successful. They have yielded increases in productivity and self-reported happiness, a drop-in demand for the healthcare system, and a positive increase in various measurable health outcomes. This isn't just seen in the prevention of disease; Blue Zones have also seen an increase in the "treatment" of long-term conditions such as diabetes, heart conditions and depression with lifestyle changes.

A Blue Zone-style innovation could potentially do a lot to help the Combined Authority's public health and wellbeing efforts. Fenland has one of the highest production in terms of agriculture and is producing fresh food for the whole country, and yet this is not being linked up to the local area and the people who live there. *"We live in the nation's breadbasket, wouldn't it be great if fresh unprocessed food were to have such a profound effect in East Anglia? Could East Anglia become a Blue Zone? If we can nudge it in the direction of a true healthcare system, in the widest possible sense, as opposed to the expensive 'Sickness care' system we currently have."*

2.5 BUURTZORG MODEL FOR COMMUNITY HEALTH

The Buurtzorg model for community health is a notable and convincing one, and one that is already being piloted in the area.

Buurtzorg, a Dutch term that translates directly as "neighbourhood care", is a social care model originating from the Netherlands. Buurtzorg 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 both to provide clients with the assistance they need, whether practical or medical, but also to train clients (and their proximate circle) to be able to practice self-care as far as they are capable. It has a proactive, rather than reactive approach. The Buurtzorg model also places a heavy emphasis on the quality of care and the time nurses spend with clients.

In organisational terms, Buurtzorg has minimal 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.[38] By eliminating vast and costly bureaucratic bodies, the Buurtzorg model 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.[39]

The model has been piloted in many regions in the UK - some formal, official Buurtzorg models and other, less formal 'Buurtzorg-inspired' models, including within St Ives and Soham in this region. Since these pilots are relatively recent, few academic case studies are available, but one published in 2018 found positive outcomes. 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.[40] 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.

A scheme inspired by the example of Buurtzorg has been piloted locally in Soham and St Ives and has delivered a great deal of positive feedback: *"These pilots are coming up to two years old, and we have learned a lot. They are delivering the best social care outcomes you will ever see. They have garnered enormous support, goodwill and real practical responses from the community, which will be everlasting."*

The Neighbourhood Cares pilot takes the principles and applies them to the local area.

"All of those people that have come into services have come in individually. And they've all had their care support commissioned individually. But nobody was looking at the community and

understanding the community. So, what if we implanted a social worker in the community? Somebody who lives, eats, sleeps and breathes the community. Someone to notice that Mrs. Johnson's milk hasn't been taken in and her curtains haven't been opened. Someone who understands the resources that are in our communities. We give them the budget (and, of course, still encourage them to spend under the budget and have their own salary out of that budget), we give them a presence in the community – a shop or a high street presence – we empower them and trust them to do the job they are qualified to do and make their own judgment. We let them review packages in the community, let them work out who they're not talking to who they should be talking to. We trust them to get things done. And that might be helping someone get home from hospital and putting a print of milk in the fridge, or making sure that their dog is taken care of while they're away. And we ask them to garner the support of the community and all the organisations in the community to look after its own. Because there is a huge amount of willingness in our communities, we are hugely rich in voluntary and community services."

The local pilots have also gleaned insights about how Neighbourhood Cares could, and we believe should, be taken forward. One of the key barriers to it working fully was flagged by many - the lack of integration with Health (it being only a Social Care initiative and funded as such). This again demonstrates how a lack of integration stifles opportunity. More time on the pilot could also focus on how it can encourage employment of nurses who are based in the area, to get the best impact from a neighbourhood nurse and to avoid people having to travel long distances - "Rather than getting in their cars and driving for hours to get there, you have, for instance, Soham people taking care of Soham people". This has not yet happened, the model has not yet managed to radically change the way that domiciliary care services are commissioned, and they are still very time and task orientated. These kinds of changes take time, and cultural changes, and recruitment, all of which are long term benefits.

We also heard disappointment that the pilots were ending, and a feeling that they had not been in place long enough to see the real benefits and change they could deliver. The success of the Buurtzorg model relies on it approaching its work as a matter of care quality, not a pursuit of profit or savings, and good care quality comes when employees have both sufficient resources and the autonomy to adjust care plans to personal needs. These factors are conducive to high approval rates among both clients and employees themselves; turnover rates among Buurtzorg nurses are considerably lower than among their counterparts working with other care companies. This in turn makes it easier to attract employees, as well as reaching new clients through GP referrals and good word-of-mouth. These benefits will not be realised immediately though and will take longer term commitment and investment. While short-term savings are not an appropriate starting point, the reality is that care like this can take pressure off the system, as it localises approaches and better draws on the voluntary sector. In the long term the evidence from Buurtzorg is that there is an approach that will both improve quality of experience and care for the users, less stress for the providers, and savings to the taxpayer.

2.6 BETTER USE OF THE VOLUNTARY SECTOR

One of the advantages of the voluntary sector is that it can be local and patient-centred in a way that is sometimes difficult for statutory bodies to be. Charities and voluntary organisations are connected to their communities. Charities are more connected to local people on the ground. When encouraging people to reach out for help, this also helps with stigma. An individual is less likely to feel comfortable picking up the phone to their local authority when they are looking for support, whereas calling a charity comes with different connotations. Charities are also likely to be doing a great deal of outreach to encourage people to seek their support.

Some of these voluntary organisations are also part of the commissioning, for instance Caring Together are commissioned by local authorities to provide caring to adults and young people and domiciliary care. These can therefore be part of Buurtzorg models of caring and nursing in the community, which empowers the nurses at the centre of the community to draw on the resources they need. They also provide a great deal of wider provisions, such as advice, support to carers, grief counselling for ex-carers, awareness raising in schools, GPs hospitals and employees, and help with emergency planning. Other charities have similarly significant roles to play, such as Age UK, Macmillan Cancer Support and other smaller local organisations.

Training for volunteers is generally very strong, as charities working in this field have to meet much of the same requirements of good practice. The Gold Standard Framework education programme was brought in to try to raise the standard of care homes and nursing homes by creating a quality mark that families could refer to, however this has struggled latterly where care homes and nursing home do not have the budgets for training. Cambridgeshire County Council and others have started using a link person for these organisations and is starting to commission more training. There are also local hospices and charities that also provide funding to train volunteers, something that can be increased.

While ageing is typically treated as a burden to the healthcare system, it is also a huge resource, as retirees are of immense value to the voluntary sector. They are also more readily taking roles as carers for children, grandchildren and are part of familial and community care chains. More can and should be done to encourage employers to consider caring responsibilities beyond women of maternity age, and to account for elderly care or wider community care. Changing households, including, but not limited to, the rise of single person households or families of choice, are also assets to community caring, and the voluntary sector.

This collaboration with employers for instance may include working with employers to provide better support to those with caring responsibilities. In schools it will help with awareness-raising around young people who are caring for family members and ensure their education is not disrupted; highlighting that for young carers it is not feasible for them to follow 'no phone' rules. For collaborations with GPs they also help to support care provider needs, for instance through encouraging GPs to be able to prescribe a break in caring. They will also work with local authorities to ensure access to public services is more accessible to carers and those they care for. In hospitals they can be in place to support carers when those they care for are in need of support.

The NHS five year forward view outlines a commitment to developing stronger partnerships with Voluntary Community and Social Enterprise organisations as part of a 'new relationship between patients and communities'. This needs to be prioritised too, and to ensure this commitment is maintained. In many areas across the country commissioners are not prioritising these relationships.

The case for devolution

One area that could be beneficial for next steps would be to make a case for a devolved health and social care budget. Such an approach supports better democratic accountability. It does so by creating a uniform resource constraint, moving health 'down' from a national level and moving social care 'up' from the local government level, and placing the budgetary constraints within the power of a democratically elected body. As the Commission we believe that the closer we can get democratic accountability to the delivery of services, the more person centred the health approach will be.

This is not just a gain for democracy, but for financial constraints. It is evident that the CCG is substantially underfunded by national and local comparison, and this presents a major barrier to change. While there is a need for greater funding for practical reasons - transformation takes investment - the funding concern is also a cultural barrier to change. This sucks the oxygen out of the room, and stifles creativity when it comes to transformation and change. A shift is needed to help those organisations and individuals who are disempowered by lack of funding, and where this is stifling transformation and innovation. It is also an opportunity for the Combined Authority to play a leadership role, and to use its role to help to address this funding gap.

Funding is and will continue to be an issue for change. It is a practical barrier and a cultural one. As CPIER also note: "Public health budgets, relative to those for primary and secondary care are low. Moreover, it is difficult to argue for the redeployment of extremely stretched resources from within the hospital sector to spend on the essentially preventative work needed to improve public health." They also outlined that the Cambridgeshire and Peterborough devolution deal anticipated meaningful dialogue with the government of the devolution of health and social care funding. 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 makes the argument that devolution is the best route to achieving systems change in the area and makes some specific recommendations as to why that is. It also connects health and wellbeing to a wider regional economic agenda. The ResPublica report,[41] meanwhile, outlines the key 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. 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.

The Commission find the detail outlined in the ResPublica report to be a convincing case for devolution and an effective starting point for building a shared vision. The current plans for integration that are happening in the region cannot be underestimated however, and need to be built upon, not reproduced or started again.

Generally, responses in our interviews around the possibilities of devolution were mixed. Some concern 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'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.

It's clear that the deficit is in some ways as much cultural as it is actual: it has become the north star to which everyone turns. Where opportunities for integration have been identified, they tend to appear where people have "found pockets of money", or where one person has really pushed for the budget to do something.

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 and next steps

In this Interim report we are advocating for a Population Health approach to health in the Cambridge and Peterborough Combined Authority. This aligns with the work of the CPIER and its focus on health and wellbeing outcomes to support economic development. A health-focused approach will necessarily result in greater prosperity, productivity and wellbeing of the people in this region.

To move this forward, we need to develop this vision and start to initiate change.

It is vital that the work of the Combined Authority has a positive impact on what is already happening in the Region. There is a great deal of positive activity already happening, and a sense that starting from scratch would be disastrous, both for morale and for engendering change.

Large acute general hospitals play a vital role at the core of a modern healthcare system. They are good at what they do. By and large the problems they face is excess demand arriving at the front door and congestion in transferring patients out of care at the back door. These potential centres of excellence have a gravitational pull that is overwhelming the most costly part of the healthcare system.

The findings of this Commission to date is that an agile, focused and well resourced Community based initiatives, well coordinated, offer an opportunity to bring about profound change at relatively modest cost compared to systemic change at the core of the system.

This has led us to the following recommendations and longer term considerations:

4.1 RECOMMENDATIONS

- The Combined Authority should make a commitment to a Population Health approach. This should build on current pools of excellence and work in partnership with existing improvement bodies
- The CA should recognise the great diversity of need in the region, and adopt an approach that ensures that suitable priorities, policies and delivery vehicles are applied in different parts of the region
- There are many interesting and productive models of contemporary healthcare underway in the Combined Authority area, and work underway to better integrate. Many are in their relative infancy and promise much. They should be nurtured and, where appropriate, expanded. The Mayor and the Combined Authority could provide local air cover and support for such initiatives.
- Social prescribing should be supported and expanded with the Combined Authority area. PCN's and the role of GP's in the broader determinants of health should be championed.
- Employers have a key role in the health and wellbeing of their employees. In the Combined Authority area we have an exemplar employer in this field, Anglian Water. The Combined Authority should engage with business, public sector employers, representative groups (such as the CBI, CIPD, Chamber of Commerce) and employees, to promote the benefits of a holistic approach.
- The CA should consider determinants of good health in their spatial planning and development strategy. Ensuring amenities such as shops, places for people to meet and talk are within walking distance. Cycling and walking should be promoted as safe, healthy activities for residents to undertake on a daily basis.
- The CA should work with schools and a retailer with a deep and broad footprint in the area to promote, nutrition and exercise. Planning in movement and healthy eating is crucial, particularly for those in more deprived areas. This should be connected with other regional approaches such as Wisbech 2020.
- If the Mayor and the Combined Authority accept the direction of this interim report then consideration should be given to the appointment of a full time Health Commissioner to act as the envoy of the Mayor and the Combined Authority in respect of leading, championing and providing support for already underway initiatives, to act as a conscience for the Combined Authority on Spatial Planning and transportation and to support PCN's around social prescribing. Other Combined Authorities areas have appointed such roles e.g. Chris Boardman as Cycling and Walking Commissioner in Greater Manchester.
- The CA should develop the case for devolution, and start work on the possible organisational structures needed to underpin devolution. This should build on: this report; the work done by Res Publica; the pools of excellence in the region; examples outside the region; a full programme of dialogue in consultation with those who could benefit; the recognition that devolution could be an enabler and an accelerator of a population health approach; Stakeholder views gathered on the vision described here, and gathered by the commission between this interim and our final report

4.2 NEXT STEPS

If the CA is in agreement with the above recommendations, the following would be the next steps of the Commission.

- Mapping the region. We will map out the region, using existing data, local understanding and current initiatives. This will help to define recommendations and priorities for the long-term vision, map existing systems and initiatives. This will also seek to evidence economic and wellbeing outcomes to initiatives already taking place.
- Conduct a cost-benefit analysis of scaling the initiatives that are in place.
- Continue our stakeholder engagement with local experts; patients and service users; employers and business networks; charities and voluntary organisations; health and social care providers, etcetera, who have expertise and insights into local priorities and strengths. This engagement will gain feedback on the recommendations of this report, and start to put together a long term vision for the health and wellbeing of the region.
- To test the feasibility and appetite for a devolved approach to health and social care, and map out how this could work in practice. Further to our interviews with those involved in other devolved approaches this should include establishing a key 'why' driver, outlining the system and governance needed to deliver that change, and developing an approach that is relevant to this region.
- To explore and outline how the role of a Health Commissioner for the Combined Authority could provide air cover, advocacy and leadership for health in the area, and put the recommendations of this report into practice.

The Commissioners will continue to work through the remainder of 2019 until the Spring of 2020 when the full report will be written and presented to the Peterborough and Cambridgeshire Combined Authority for consideration.

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.

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Our thanks to Wendi Ogle Welbourn, Gillian Beasley and their teams for producing a paper on the new model of health and social care, to contribute to this report.

Footnotes

[1] Cambridgeshire and Peterborough Independent Economic Review, Final Report, 2019

[2] This summary outlined in a paper produced by for this report: "Delivering a New Model of Health and Social Care across Cambridgeshire and Peterborough, Paper for the Combined Authority- DRAFT"

[3] Deloitte: The Transition to integrated care: Population health management in England

[4] ResPublica, Devo-health: a new approach to the public's health in Cambridgeshire and Peterborough, 2018, P18; see also Cambridge and Peterborough – Drivers of the Defecit, September 2018.

[5] The Health Foundation: "Additional £3.2bn a year needed to reverse impact of government cuts to public health services"

[6] ResPublica, Devo-health: a new approach to the public's health in Cambridgeshire and Peterborough, 2018, p.6

[7] Cambridgeshire Health and Wellbeing Strategy, 2019 (DRAFT)

[8] House of Commons Library: Research Briefing – Women in employment

[9] IFS: "Cost pressures on the NHS will only grow: it needs a long-term funding solution, and that is likely to mean substantial tax rises"

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

[11] Nuffield Trust: "Are we expecting too much of the NHS?"

[12] Deloitte: The transition to integrated care: Population health management in England

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[15] Public Health England: "Turning the tide on tobacco – Smoking in England hits a new low"

[16] ONS: Adult smoking habits in the UK

[17] Nuffield Trust: "Are we expecting too much of the NHS?

[18] Cambridge and Peterborough Independent Economic Review, Final Report, 2018.

[19] ibid

[20] Nuffield Trust: "Are we expecting too much of the NHS?"

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

[22] Heart disease is the commonest cause of years of life lost (YLL) due to premature death, with over 800 years per 100,000 population in 2016. Next is lung cancer (nearly 500 years per 100,000 population), then stroke, chronic lung disease, dementia and self-harm. The total years of life lost to premature death in Cambs in 2016 was 7,513 per 100,000 population compared to national avg of 8,941 per 100,000. (Public Health, Cambridgeshire, 2018.).

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[27] Working for a healthier tomorrow: work and health in Britain, Dame Carol Black, 2008. https://www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain

[28] Cambridgeshire and Peterborough Independent Economic Review, Final Report, 2018.

[29] Thriving at Work: a review of mental health and employers, Paul Farmer and Lord Stevenson, 2017.

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[31] These findings, and the summaries in this section regarding workplace mental health will be published in an extensive research study by Tomorrow's Company. This report "Tomorrow's Mental Health" will be published in Autumn 2019.

[32] Take Care: How to be a Great Employer for Working Carers,David Grayson, 2017.

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