UNIVERSITY OF BATH

The Bath & North East Somerset Community Wellbeing Hub

An evaluation

November 2021

IPR Institute for Policy Research

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Acknowledgements

The Institute for Policy Research (IPR) wishes to thank all the participants – users, councillors and stakeholders - in the research. Particular thanks go to the senior staff of Bath & North East Somerset Council, Virgin Care and Riviam, who between them facilitated access for us to research participants, data, and relevant documentation for the study.

We also wish to acknowledge the intellectual input of students on the University of Bath MSc in Sustainability and Management, who examined the Hub as a case study in their programme. We thank Dr Kostas Iatridis, Senior Lecturer in Business and Society and Director of Studies for the MSc, for their engagement.

We gratefully acknowledge additional research assistance provided by Elena Ahonen, Daniel Mtonya and Laura Smyth, and data visualisations by Arron Gosnell.

Introduction

The Community Wellbeing Hub ('the Hub') - originally called the Compassionate Communities Hub (CCH) – is a multi-agency, single point of access for wellbeing services in Bath and North East Somerset (B&NES). It offers a range of advice services for local residents who need help with employment, housing and social security benefits; community-based health and wellbeing services, for physical and mental health needs; and access to essential supplies, such as food and medication. It has been a core part of the support for residents provided by local public services and the voluntary and community sector during the Covid-19 pandemic.

The Hub was set-up and began operating in a remarkably short period of time. On 16 March 2020, Prime Minister Boris Johnson made a televised public address to warn of the worsening Covid-19 pandemic in the UK and stated that serious measures would be required to contain it. On 23 March the first Covid lockdown was announced, and it came into force on 26 March. In B&NES there had been a series of preliminary meetings between the local authority, Virgin Care and several Third Sector organisations during March to discuss the need for an emergency response to the forthcoming Covid lockdown. On 20 March the Hub began operating.

At its outset the Hub was a collaborative initiative involving the B&NES local authority, Virgin Care, seven Third Sector organisations[1] and Riviam Digital Care (a private sector software development company, hereafter 'RDC'). The speedy establishment of the Hub was possible because it built on a series of existing relationships and initiatives involving different combinations of these partners.

The idea of a focal organisation that provided multi-agency, integrated support had already been under consideration for B&NES and Virgin Care in the year preceding the pandemic. It was pre-figured to some extent by the 'Prime Provider' arrangement that Virgin Care already had with a range of Third Sector organisations to provide support and advisory services for B&NES. A number of key figures amongst the commissioned providers were also linked into a separate 'Compassionate Community' initiative in the authority area that was being led by 3SG (a coordinating organisation for the Third Sector in B&NES), to which the Council was also a signatory.

The Compassionate Community movement has become an established movement with a distinctive community development philosophy in the UK over the last ten years.[2] This conjunction led to 3SG and other organisations being centrally involved in the March discussions about how the B&NES Covid response would be set-up. Crucially, at the outset of the Hub, 3SG reported that they mobilised around 2,000 community-based volunteers for the Hub[3]. Other organisations and groups not initially associated with the Hub, such as parish groups and local community organisations, also swung into action and it is estimated that there were over 6,000 volunteers across B&NES helping out.

[1] Age UK, Bath Mind, Citizens Advice Bureau, Cleanslate, DHI, Reach, 3SG. The housing association and service provider, CURO, joined as an eighth member shortly after start-up.
[2] Compassionate Communities-UK. *What are Compassionate Communities?* Accessed at: https://www.compassionate-communitiesuk.co.uk/what-are-compassionate-communities [Last accessed 29/09/2021].
[3] B&NES had been commissioning a Community Volunteer Service through Virgin Care from April 2018.

The other prior relationship on which the Hub was able to build was between Virgin Care and RDC. Virgin Care were already working with a customer relationship management (CRM) system that had been developed by RDC for their clinical care system and RDC were then asked if they could quickly develop a similar system to underpin the work of a multi-agency emergency response Hub[4]. A physical location for the Hub was acquired to rent from a local charity (Dorothy House), a grant was received from St John's Foundation and B&NES made a financial contribution for the rent of the building, the RDC input, IT equipment and miscellaneous funding for other resources such as food supplies, and pool cars. Aside from developing the software system (hereafter referred to as the Riviam), RDC were also central to the installation of the telephony and IT systems at the new premises in the village of Peasedown St John.

The Hub provides services online and by telephone only, from the Peasedown St John offices. Staff from Virgin Care's wellbeing service form the core of the team, but 12 organisations have had staff working in the coordination centre. Calls are triaged by a call team and then channelled into 'pods' to provide tailored support. Originally, there were 10 pods: emergency food, shopping, medication, mental health and wellbeing, public health advice, money matters, housing, transport, advice on keeping fit, and family support. An employment and skills advice pod was added later.

In this report, we provide an early evaluation of the Hub, drawing primarily on qualitative semi-structured interviews with users of the Hub's services, its stakeholder organisations, volunteers and a range of local councillors. We also make use of the (relatively limited) quantitative data that is available on the Hub's operations and draw on academic and 'grey' literature where relevant and appropriate. The research was conducted, and the report drafted, by a team of researchers and academics affiliated to the Institute for Policy Research (IPR) at the University of Bath.

Across England, the Covid pandemic led to rapid changes in the organisation and delivery of public services. Local authorities, the NHS and the voluntary and community sectors had to find new ways of working together to ensure that vulnerable people were cared for, services could be accessed online, and the public's health was protected. In many cases, local authorities built on existing partnerships, and used collaborative services and existing data platforms to meet the new challenges they faced. In other areas, NHS-led innovations in GP and community health services provided an infrastructure that could be scaled up in the pandemic. In some parts of the country, local communities and the voluntary sector took the lead in self-organising mutual aid, and then knitted these efforts into the fabric of local public service provision as it evolved to support local people. Almost everywhere, rapid reform took place that transformed relationships between communities, voluntary sector organisations and public authorities.

The creation of the Hub in B&NES was therefore part of a wave of innovation that took place throughout England during March 2020 and the months that followed. Comparing the Hub to 'peer' reforms in other local authorities and NHS areas can therefore offer some valuable lessons to partners in B&NES and the communities they serve. In Annex B of this report we list illustrative examples of those reforms, structuring them according

[4] RDC currently has licences in place with the major GP clinical systems to support integrated data management for individuals. These are used to support integrated care in other situations and were not mobilised for the Hub.

to a rough tripartite typology of local authority-led, NHS-led and community-initiated. Many of these examples take the form of integrated 'hubs' and co-located services, but vary considerably as to their structures, modes of stakeholder and community participation, and relationships to the wider local democracy.

The report is structured as follows. Chapter 1 provides a brief overview of the economic, social and demographics characteristics of B&NES, and the organisation of its public services and voluntary sector. Chapter 2 sets out our research framework and methodology. Chapter 3 reports on the interviews with users and the impact of the Hub on its clients. Chapters 4 and 5 report on the organisational and systemic impacts of the Hub respectively, drawing primarily on the interviews with stakeholders and councillors. Chapter 6 concludes with a discussion of the future of the Hub and the contribution it can make to the wellbeing of the residents of B&NES after the need for Covid-19 pandemic emergency services has passed.

Chapter 1: The local context of Bath & North East Somerset

Bath & North East Somerset (B&NES) is a prosperous part of the UK, with low unemployment and low rates of poverty, but nonetheless significant socio-economic inequalities. With a population of a little over 190,000, it is a medium sized local authority area. Its population is an ageing one - the number of people aged 75 and over is projected to rise from 16,600 in 2016 to 22,600 by 2029, or by 36% - but it also has a large student population. Healthy life expectancy at birth for both men (65.38 years) and women (67.48 years) in B&NES are higher than national levels (62.9 and 63.3 respectively)[5].

B&NES also has a skilled and educated population. A total of 57.1% of employees are in higher skilled occupations, compared to 54.4% in the West of England and 52.5% nationally. Bath has two universities and a large further education college. The National Health Service also has a strong local presence, including through the Royal United Hospital, which is the largest single employer in B&NES.

The City of Bath is a major visitor attraction and tourism is a source of significant revenue to the local authority, which owns the Roman Baths. Bath is one of the most visited places in Britain, and UNESCO World Heritage status sustains its position as a premier European city break destination. Its retail centre has been relatively successful in supplementing local consumer demand with visitors from outside.

Despite this prosperity, B&NES is marked by significant inequalities in income and wealth, access to affordable housing, and education and health outcomes. Its labour market provides lots of good, well-paying professional jobs, but its tourist, hospitality and retail sectors depend on large numbers of relatively low paid workers. There is insufficient affordable housing to buy or rent. Historic disparities persist in children's life chances and in the health and wellbeing of adults from different social class backgrounds. There are areas of concentrated disadvantage in the communities of North East Somerset: for example, Twerton has a child poverty rate of 35%, compared to 19% (after housing costs) in the local authority as whole. [6]

Covid-19 has also had a significant impact on the economy of the South West, where B&NES is located. According to Ernst & Young, the South West experienced the largest regional contraction reported in England during the first phase of the Covid pandemic, and it forecasts that Gross Value Added and employment growth in the region will lag behind the UK average over the next four years. [7] The region's hospitality sector, which has been badly affected by Covid, acts as a significant drag on growth prospects. In B&NES, the impact on the local authority budget of COVID-19 and central government

[5] Office of National Statistics, (2021). *Health state life expectancies, UK: 2017 to 2019.* Accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2017to2019 [Last accessed 29/09/2021].
[6] Institute for Policy Research and The Good Economy, (2020). *Bath Beyond 2020: Creating a Resilient Economy Together. A*ccessed at: https://www.bath.ac.uk/publications/bath-beyond-2020-creating-a-resilient-economy-together/attachments/Build-Back-Better-Report.pdf
[7] EY, (2020). *The economic Performance of England's regions: UK Regional Economic Forecast.* Accessed at: https://assets.ey.com/content/dam/ey-sites/ey-com/en_uk/topics/growth/economics-for-business/ey-the-economic-performance-of-englands-regions.pdf [Last accessed 29/09/2021].

cuts has also been significant, with £20m in spending reductions made for FY2020-21 and a further £8.5m in cuts to be made for FY2021-22.

Local geography and the organisation of public services

The City of Bath differs from the rest of B&NES significantly with regard to the density and diversity of its population – it is 12 times more densely populated than the rest of the local authority area and accounts for half of the B&NES population.[8] Apart from the City of Bath, the main towns and villages in the local authority area are Midsomer Norton, Radstock, Westfield, Paulton, Saltford, Peasedown, and Keynsham. Some two-thirds of B&NES is green belt land.

B&NES is a unitary local authority, responsible for the provision of local public services, such as adult social care, children's services, environmental services and public health. It focuses its corporate strategy on five central commitments: preparing for the future, focusing on prevention, delivering for local residents, tackling the climate and ecological emergency, and giving people a bigger say. B&NES is one of three constituent local authorities that make up the combined authority sub-region of the West of England (WECA), which has a directly-elected Mayor. The West of England Mayor has responsibilities for regional transport, skills, housing and economic development. A number of the towns and villages of B&NES also have parish and town councils.[9]

The NHS in B&NES is now part of the new Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership Integrated Care System. The BSW Partnership brings together a Clinical Commissioning Group, three hospital trusts, private providers, a mental health trust, an ambulance trust and voluntary sector organisations. As an integrated care system, it spans primary, community and secondary care, and social care.

Since 2016, Virgin Care has been commissioned by B&NES and the NHS to provide community health and care services. As a consequence, it has played a central role in the Hub, leading on the food, wellbeing and public health pods. It works alongside - and sometimes directly commissions - key third sector organisations such Citizens Advice B&NES, Bath Mind, Age UK B&NES, and others noted in the introduction. Funding support for the Hub was provided by B&NES Council, and to 3SG by the St John's Foundation, an historic local charitable foundation. The major housing association in B&NES is CURO, which owns and manages 13,000 homes in the West of England and provides care and support services to its tenants and customers. Developing Health and Independence (DHI) is a regional provider of services and supported housing to socially excluded young people and adults and is another key partner in the Hub.

[8] Bath & North East Somerset Council. *Characteristics of Bath and North East Somerset's Area.* Accessed at: https://www.bathnes.gov.uk/services/environment/pollution/contaminated-land/2-characterisitics-bath-and-north-east-somerset-cou [Last accessed 29/09/2021].

[9] Bath & North East Somerset Council, (2021). *Corporate Strategy 2020-2024.* p.13. Accessed at: https://beta.bathnes.gov.uk/sites/default/files/2021-04/JB773_BANES_Corp%20Strat_A4_Bookletv2_0.pdf [Last accessed 29/09/2021].

The infrastructure provider for the third sector in B&NES is 3SG. It has provided support to charities and social enterprises in B&NES since 2016. 3SG is a founding member of the Compassionate Community movement.

Chapter 2: Research framework and methodology

Our study of the Hub was guided by a tripartite framework: it sought to establish the impact on the intended users, on the organisations involved and at a systemic level in wider social and political processes. The impacts at each of these levels were explored using a combination of quantitative and qualitative data. The quantitative data consisted of anonymised data from the Riviam, and descriptive quantitative data provided by B&NES and Virgin Care from, and about, the Hub system.

The qualitative data was generated by a series of structured interviews with respondents relevant to each of the three levels of impact: with users of the Hub; with key respondents in the collaborating organisations; with volunteers who worked for the Hub in its early months; and with a mixture of B&NES elected ward councillors and parish councillors in the authority. Because of the small scale and preliminary nature of the study there was no intention to aspire to a representative sample, and rather these qualitative interviews were intended to provide diverse insights into the functioning of the Hub and its impacts at the three levels. In total 44 interviews were conducted: 12 users, 14 organisation representatives, eight volunteers and eight councillors.

Users

Contact with users of the Hub was arranged through Virgin Care. At the time of their initial contact with the Hub the users had not been asked to give consent to any follow-up study, so for data governance reasons a new procedure was developed to identify willing client interviewees. During follow-up calls to people who had been using the Hub for support the study was explained, and the users were asked whether they would give their permission to be contacted by the University of Bath researchers. Virgin Care agreed to provide a list of around 20 willing Hub users with their contact details. It was agreed that this pool should try to include a balance between men and women, that it should include residents from across different areas in B&NES and that not all would be people who had been instructed by government to shield. A list of 21 users who were willing to be interviewed was provided, 11 of whom were female and 10 male.

These users were then contacted by the University of Bath researchers, who provided a more detailed explanation of the study and what the interview would consist of. The Hub users were asked to give their consent to be interviewed on the basis that their responses would be entirely anonymised. In the end 12 of the Hub users were contactable and agreed to be interviewed. The structured interview schedule for users consisted of 18 questions, 15 of which were open ended and three of which asked the respondent to answer using a pre-set scale. The interviews were conducted by phone and permission was given to record them. On average these interviews lasted 20 minutes.

Organisations

There were 13 collaborating originations at the start-up of the Hub. Ten of these were Third sector organisations, who were working with Virgin Care, B&NES and RDC. Each organisation was asked to identify the person or persons who had had the main role in working with the hub and all of those were interviewed. Two interviews were conducted with key Virgin Care staff and two with key B&NES staff. A single interview was conducted with two RDC staff. In total 15 interviews were conducted. These were

standard structured interviews that were slightly adapted for each organisation and that contained some possibility for developing new themes as the interview progressed. The interviewees were sent an information sheet and consent form prior to the interview. Consent was reaffirmed at the start of each interview. The interviews were recorded and transcribed. The interviews lasted on average 41 minutes with the longest being one hour and seven minutes and the shortest being 30 minutes.

Volunteers

In the first weeks of the operation of the Hub, 3SG mobilised 2000 community volunteers. Of these, some 800 were actively used during the first wave of lockdown. Eight of these 3SG volunteers were interviewed for the study. The volunteers were contacted by 3SG who asked whether they would be willing to be interviewed for the study. A randomised selection of volunteers who were willing to be interviewed was provided to the University of Bath team and eight were selected for interview. The structured interviews contained 21 questions and an opportunity at the end for the interviewees to raise any issues that they felt were important but that had not been addressed. The interviews were recorded and lasted on average 29 minutes.

Politicians - Councillors

All B&NES ward councillors and parish councillors were sent a letter by email, soliciting their participation in the study. The intention was to select a sample of councillors who were representative of different types of constituencies in B&NES, including from across the City of Bath, smaller urban centres and rural areas throughout the authority area. It was intended that the study would interview representatives whose constituencies were at different points in the distribution of the English Index of Multiple Deprivation.

The letter explained the purpose of the study but the response to the letter was very poor (although better amongst parish councillors than ward councillors) and alternative means of recruiting interviewees to the study had to be adopted. It is not entirely clear what explains this low level of engagement with the study.

A more purposive strategy was adopted. Follow-up emails were sent to specific ward and parish councillors in a selected range of constituencies. In addition, the B&NES Council Cabinet member with specific responsibility for the Hub was asked to recommend ward councillors who had had particular contact with, or interest in, the Hub. The email to these councillors was followed-up by a request from the B&NES Cabinet lead for them to participate in the study. When the interviewees agreed to be contacted by the study, they were sent a more detailed explanation of the study and a consent form for them to agree to or reject. In the end only three ward councillors agreed to be interviewed and five parish councillors.

The structured councillor interviews consisted of 23 open ended questions and an opportunity at the end for the respondents to raise issues that they felt were important but that had not been covered in the interview. The interviews were recorded with permission and took on average 34 minutes (the shortest being 15 minutes and the longest one hour and two minutes).

All the recorded interviews were professionally transcribed. They were analysed using Taguette, a qualitative data analysis programme.[10] Anonymised quantitative data was

[10] See, https://www.taguette.org/

made available from the Riviam by RDC in an xlxs spreadsheet file, containing sheets on patients (gender, year of birth, Lower Layer Super Output Areas), referrals, referral steps, workflow steps, workflow organisation and pathways. Duplicate records were removed. This data was analysed to provide basic descriptions of the Hub, its users and their pathways, as well as the data visualisations contained in this report.

Chapter 3: The users of the hub

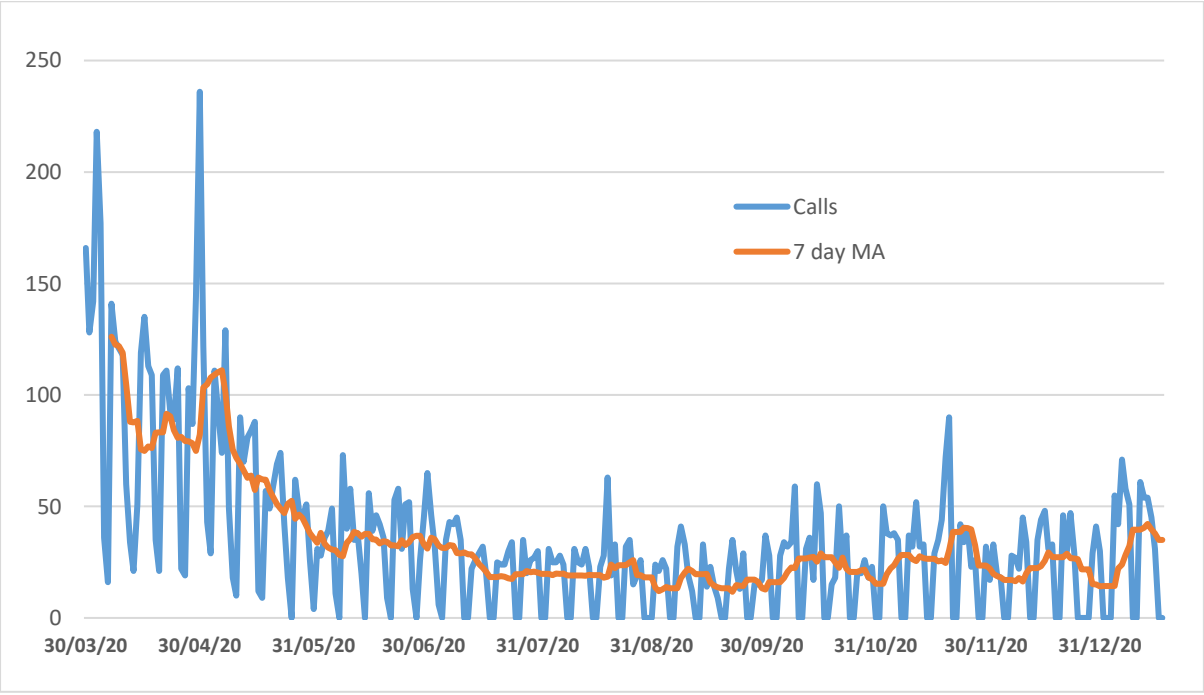
The Hub was established just before the first Covid-19 lockdown in England with the purpose of providing a range of support to citizens of B&NES who were facing difficulties because of the lockdown and the wider effects of the pandemic. An assessment of the efficacy of the Hub and its future potential contribution hinges around the extent to which it has been effective in reaching and supporting its target population. The Hub was operational by the end of March 2020.

As noted in the introduction, the Hub was created to respond to the Covid-19 pandemic but built on a number of pre-existing initiatives that were already underway in the authority area: the first being an integrated services platform being developed by RDC for Virgin Care and the second being the Compassionate Communities initiative that was being developed by 3SG. In this section of the report, we explore the functioning of the Hub and its impact on vulnerable people in B&NES. To do this we draw on both the quantitative data that has been made available from the Riviam system and the qualitative data that has been generated from the 12 user interviews.

Who, when and where

Between 20 March 2020 and 21 September 2020 the Hub received over 7800 calls. In Figure U1 we show the pattern of calls to the Hub during the whole of 2020. As can be seen by mid-June, calls to the Hub had levelled off at a fairly low level and, whereas it had previously been open seven days week, a decision was taken at that time to close the Hub to calls on Sundays. By mid-July it had also closed to calls on Saturdays.

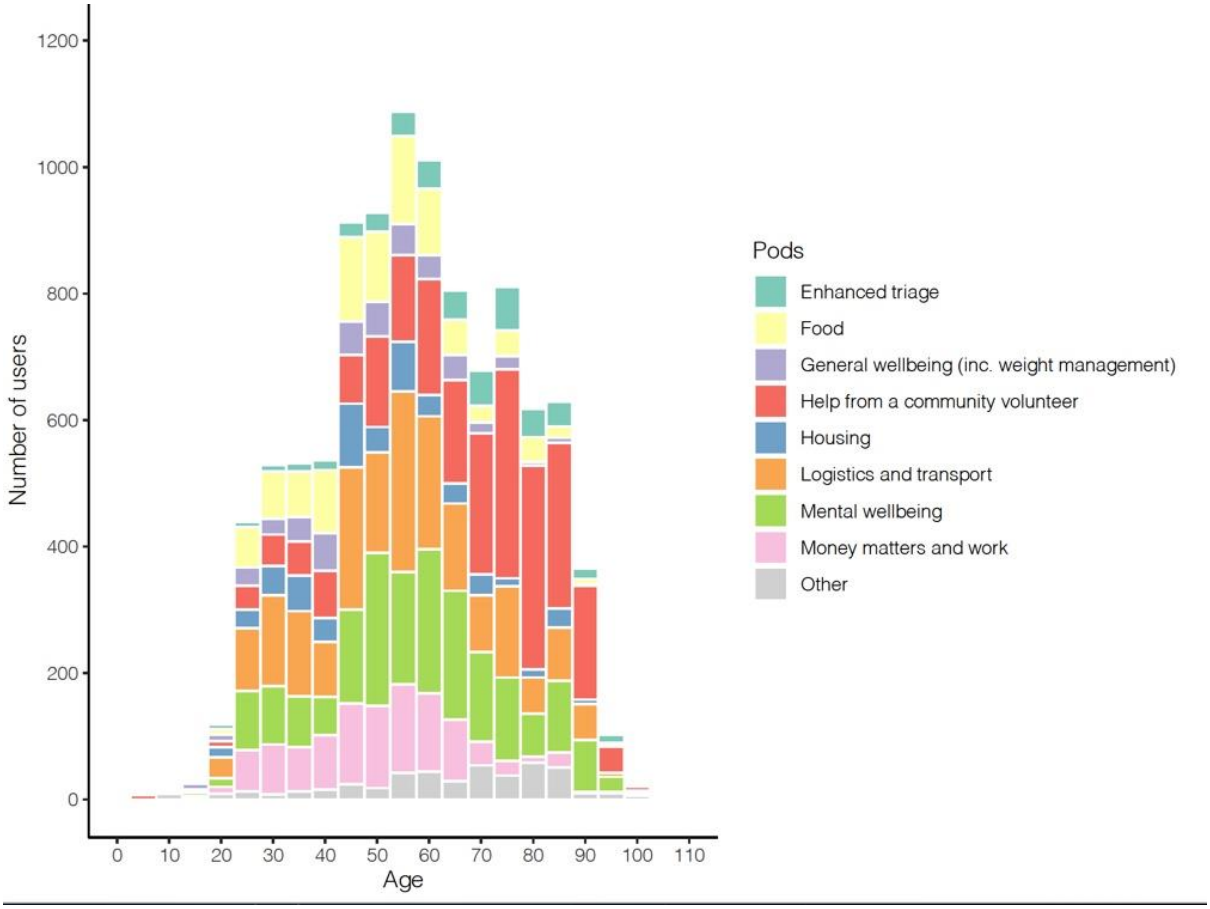
Figure U1: Daily Hub triage calls and seven day moving average, 30 March 2020 to 15 January 2021



Source: Riviam Database 2021.

Figure U2 shows the age demographic of the supported population[11]. The age profile of the population shows that support was skewed towards older people. The extent to which the Hub was known to other younger age groups that might have been affected by the lockdown (for example, school children struggling with being out of school or young adults facing unemployment) is a matter for consideration as the plans for the future of the Hub evolve.

Figure U2: Age profile of clients by pod referral

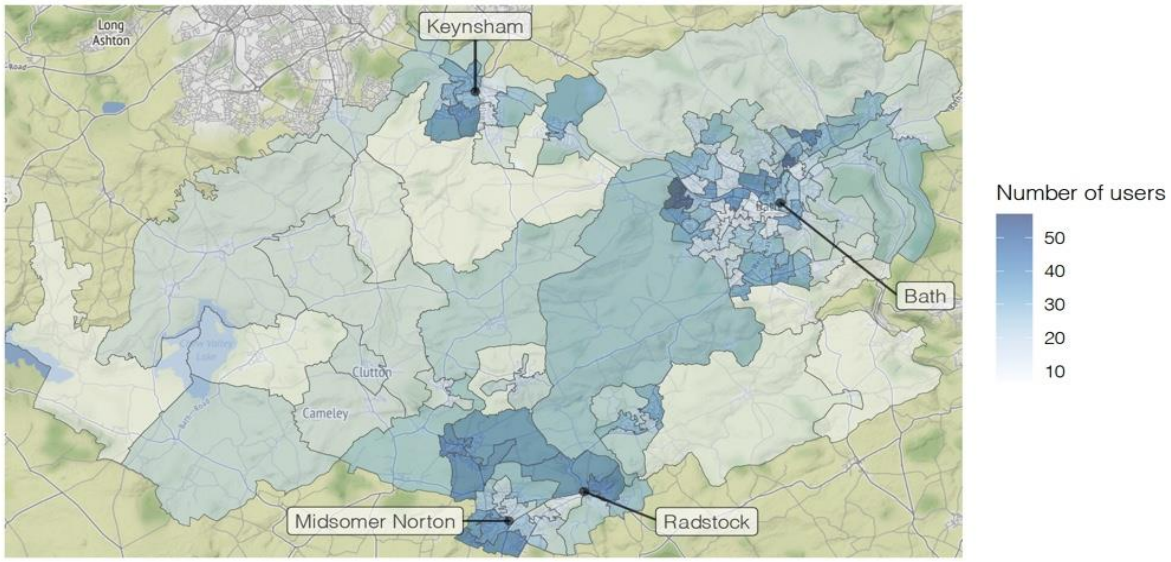


Source: Riviam Database April 2021.

Figure U3 shows the geographical distribution of the population that was supported by the Hub during 2020.

[11] A group of 9–10-year-olds were also reported as having been supported by the Hub but this was 'school meals support' and since these were an exception to the routine business of the Hub this group has been excluded from the figure.

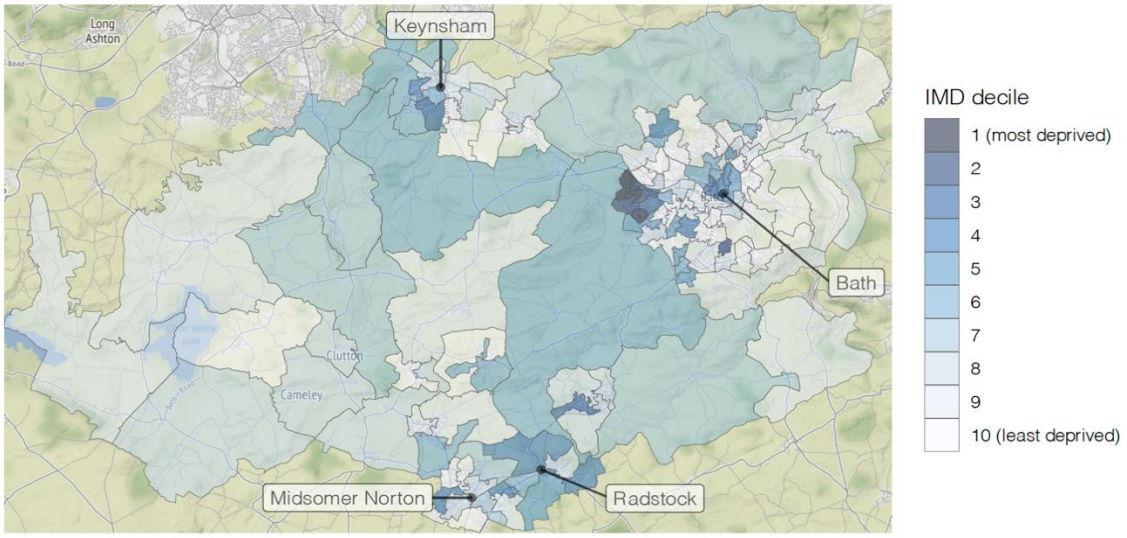
Figure U3: Geographical distribution of users across Bath & North East Somerset



Source: Riviam Database 2021.

As explained above, although B&NES is generally a prosperous authority area, it nevertheless has a number of areas of significant deprivation. In Figure U4 the English Index of Multiple Deprivation (EIMD) rankings for the Lower Super Output Areas (LSOA) in B&NES are shown. When these two maps are compared it becomes apparent that the distribution of cases supported by the Hub broadly corresponds to the EIMD distribution. Although this cannot be taken to indicate that the most vulnerable people in these areas were served by the Hub, it nevertheless gives a sense that it was reaching the most appropriate geographical areas.

Figure U4: Geographical distribution (by decile) of Index of Multiple Deprivation Ranking across Bath & North East Somerset



Source: Riviam Database 2021.

Becoming aware of the Hub

The majority of the respondents in the qualitative study reported that they had become aware of the Hub either because they had received a shielding letter, which gave the Hub contact details, or because they were told by someone (usually a relative) who had received a shielding letter. In two cases, the users became aware because of the Compassionate Communities Hub leaflet that was distributed to homes and was posted in prominent locations (a leaflet had been received through the door by one and the other had seen the leaflet in a local pharmacy). In two cases the local pharmacy had had an important role in drawing attention to the service and in two other case the respondents had been told about the hub by support services that they were already in contact with.

Contact and communication

In general, contact and communications with the Hub were reported as good. In most cases the clients called the Hub number after either seeing it in a shielding letter or online, or were advised to call it by someone else. In two cases the Hub called the client after they had been asked to do so by a relative of the client. The pattern of communications is that there were usually a number of calls at the outset to establish the support required - most often the Hub making contact with a volunteer to collect and deliver medication or arrange for food deliveries. In a number of cases there was a further ongoing programme of contact from the Hub, either just to check-up or to deal with more complex support needs. In one case, the client reported that their regular communications with the Hub had broken down and after that no further calls had been received. Notably two of the 12 clients that were interviewed reported that their first contact with the Hub had been when they called to offer to be a volunteer. Neither ended up being a volunteer but instead received support from the Hub.

What support

As has been mentioned, most of the clients who were interviewed in the study had received shielding instructions from government. This meant that the main forms of support that were discussed in the interviews were for the collection and delivery of medication and for food deliveries. In the case of medication, the clients were put in contact with a volunteer who then collected and delivered medication, usually on a regular basis.

Support with the supply of food took a number of different forms. This included providing advice about how the client could get themselves prioritised for food deliveries by online supermarkets; arranging for volunteers to do occasional food shopping; and the delivery of food packages from the Hub. In a number of cases there was some confusion in relation to the delivery of food packages by central government. In one case the client ended up with too much food and in two of the cases interviewed here the Hub arranged to come to pick up government food packages that were not needed or not wanted.

Only three of the interviewees reported the more complex, multi-agency interventions that the Hub was intended to provide. All three of these involved an aspect of mental health and counselling support. One of these was reported as being very successful and the client described a range of different forms of support that had been provided to produce a significant change in their life and work circumstances. A second was a good model of meaningful but modest support, entailing welfare advice and support to stop smoking. The third of these was reported as unsuccessful and the client described that

the support and contact had broken down, even though they regarded themselves as still in need of support.[12]

It is worth noting that those clients who were assigned volunteers to collect medication or shopping were positive about them. Many described the volunteers as polite and helpful and for some, the regular contact (even though socially distanced) was appreciated.

> *... the particular volunteer that I had was exceptionally good, and without being over the mark, because obviously you still want your privacy and that, and so was very respectful. It was that extra touch of just seeing me that day walking my dog, and just to stop and say, "How nice to see you up and about again," a lot of people wouldn't have bothered with that.*

Satisfaction with the Hub

In the interviews the clients were asked to rate their level of satisfaction with the support that the Hub had provided them. They were asked to do this using a five-point scale, where one was the lowest score and was 'very dissatisfied' and five was the highest score and was 'extremely satisfied'. As Figure U5 shows most of the clients reported that they had been extremely satisfied with their experience of the Hub. The two clients who reported less than five each had very specific issues in their relationship with the Hub that explained why they were either dissatisfied or less than fully satisfied.

In the narratives explaining these positive satisfaction responses many of the clients expressed the view that the support had come at a time of considerable worry, that it had been timely and effective. Most said that they were extremely grateful for it at the time and still felt that it was a potential channel of support.

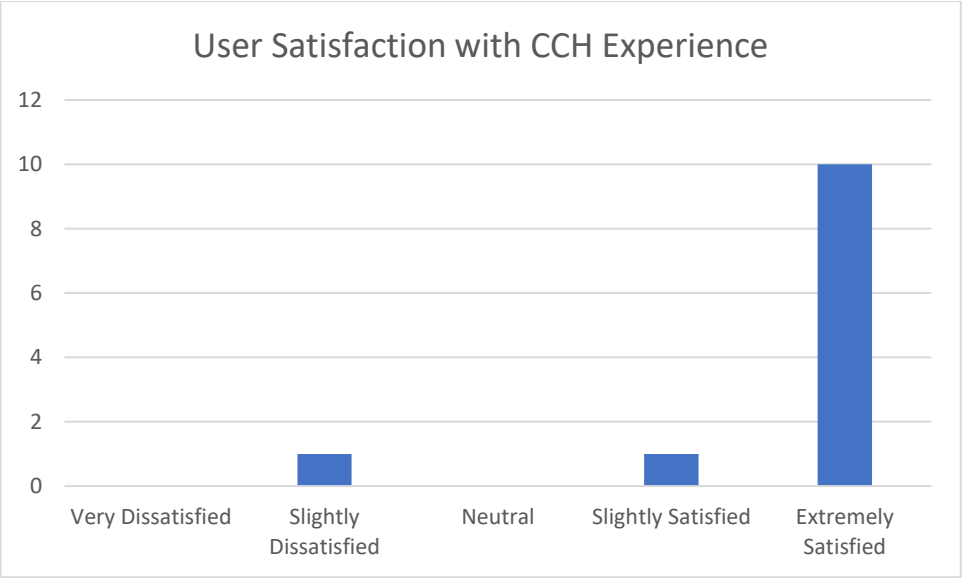
> *I think they were brilliant, they stepped up when I really needed them at the start of all of this and gave me a lifeline really. Without their support I think actually to tell you the truth, I was really in a panic and didn't know quite what I was going to do before they actually stepped up and gave me the support they did really. So I've got nothing but praise for them really.*
>
> *Without even thinking about it, it's a five. You know, the fact that the service is there...*
>
> *I think it was the attention to detail and that they were very polite, they didn't judge you. ... So they've just gone all out, they pulled all the stops out. ... they have been quick off the mark, they've done everything that I've asked, and I can't ask for anymore. I know they're there, and that's nice knowing that they're there if you're stuck.*

Another said:

> *I think five, yeah, because I wouldn't have found out, there were so many things that they pinpointed me to services or told me to go through my GP, or whatever it was that I was asking, I don't think I would have managed without, you know. I couldn't have done it.*

[12] In this case the interviewer was asked to contact the Hub to ask them to resume contact with the client. The request was passed on to the Hub.

Figure U5: Level of user satisfaction with the Compassionate Community Hub experience



N = 12. Source: User Interviews Jan-Feb 2021

Wellbeing effects

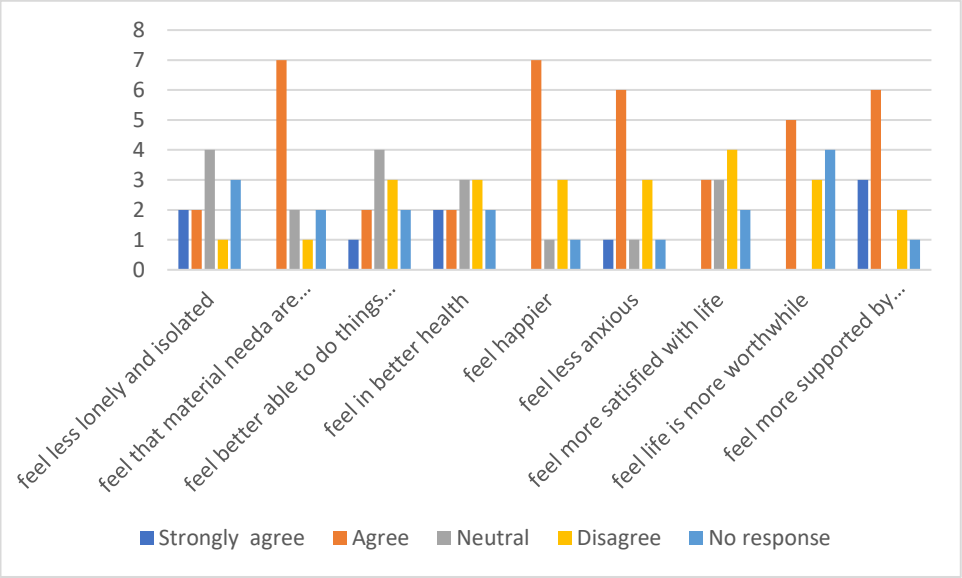
In Autumn 2020 the name of the Hub was changed from the Compassionate Community Hub to the Community Wellbeing Hub. This name change, and in particular the incorporation of the notion of wellbeing, reflects the statutory responsibility of the local authority to promote the wellbeing of its citizens and also the increased attention to the relationship between health and wellbeing in the UK health and care systems.

The name change also reflects the longer-term vision by some stakeholders in the Hub of having it as a fundamental part of the system for supporting community resilience and citizen wellbeing. To engage with this change, but also because the improved wellbeing of clients is the ultimate *raison d'etre* of such interventions, the study carried out a preliminary exploration of possible wellbeing effects of the Hub support on clients.

Using a series of questions that build on the UK Office of National Statistics (ONS) conceptualisation of personal wellbeing[13], the clients were asked to rate the extent that they agreed with a series of statements on different aspects of personal wellbeing after having had support from the Hub. Their responses used a four-point scale ranging from 'Strongly Agree' to 'Disagree', and with the option of a fifth response that was either a non-response or that the statement was not seen as relevant.

[13] The interview used the four ONS questions/statements (on satisfaction with life, worthwhileness, happiness and anxiousness) and added a further five statements on material and relational wellbeing which pertained directly to the intended effects of the Hub operation. See, Office for National Statistics, (2019). *Measures of National Well-being Dashboard.* Accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuresofnationalwellbeingdashboard/2018-04-25 [Last accessed 29/09/2021].

Figure U6: Reports of effects of Hub support on aspects of client wellbeing



N = 12. Source: Hub Study User Interviews Jan-Feb 2021

In Figure U6, we see the distribution of responses of the 12 respondents to the nine statements. While it is difficult to attribute the positive responses to the Hub support in any simple and direct fashion it is nevertheless encouraging that a number of the statements elicited strong positive responses. The fact that a good number of the interviewees felt that after their interaction with the Hub their material needs were better met; that they felt happier; that they felt less anxious; and that they felt more supported by their community, can all be interpreted to reflect positively on the work of the Hub.

Some of the other aspects of wellbeing either could not be expected to be improved by the interaction or the interviewees felt that they were not able to provide a response. For example, since many of the interviewees were shielding because of chronic health conditions, it is not surprising that more than half of the interviewees felt that their health had not improved. One of the most striking positive results shown in Figure U6 is that nine of the respondents either 'agreed' or 'strongly agreed' that they felt more supported by their community.

Users' thoughts on the way forward

In the interview the clients were asked to propose ways that the Hub might be improved or further developed. While, in general, there was strong support from the interviewees, a key theme that came across in these discussions was there could be improvement in the visibility of the Hub. Although two letters publicising the Hub were sent to all households in B&NES, a number of the interviewees felt that they had been fortunate to come across it or be pointed to it by others.

> *I think the key thing for me would be it was almost as if we stumbled across them. I know that they must have limited resources, so that's a challenge, they can't help absolutely everybody I'm sure. But it was the fact that it literally was my daughter stumbling across a note which kind of triggered my contact with them. So I think there are lots of people that wouldn't know about them.*

Another user said:

I think the letters that came round, some of them was misguided from the council, by saying the Community Hub is available if you have any problems, but a contact number would have been useful. But you can easily find the Community Hub number, but if I was older and had problems, how would I have contacted them? But as it happened, they contacted me, I contacted them when I needed them, and they were there.

And another noted that:

... maybe just more awareness for the community that the hub is there. Because just the main thing is, it's not necessarily a negative thing, it's just that we were not aware that the hub was there until they called us, rather than calling them. But yeah, I don't know how that would be – but just making people more aware essentially. But yeah, but they were quite helpful when I contacted them, so I'm sure more people would be appreciative of the help that they would offer.

This reinforces a broader impression that for the Hub to be effective and sustainable in the future it will be necessary for it to increase its visibility and accessibility. It needs to reach more of the population in B&NES who are vulnerable and in need of support.

The accessibility issue also highlights the potential problems of IT literacy and access. It was felt that for many of the older potential users that having to depend considerably on accessing information on online might be a problem. While many of the Hub's users were grateful for their repeated phone calls and with brief interactions with volunteers, some felt that the mental health support aspects of the Hub could be enhanced by occasional face-to-face meetings:

I personally think it's a great thing, and as long as somebody doesn't start cutting, which everybody's going to be open to, doesn't start cutting on these, it's a very, very good service. I think the Hub is one of the ones that you really, really need to keep, especially for a generation that's getting older.

Overall, however, it seems that Hub had a positive impact on the people who accessed it. This sample of interviews does not include as many examples of complex multi-agency support as might have been hoped for, but it is this person-focussed, integrated support that provides the most promising aspect for the Hub role in a post-Covid era.

Chapter 4: The Hub's organisational impact

In this section we consider the organisational aspects of the Hub. This includes both consideration of the functioning of the Hub during the first Covid-19 lockdown and its impacts on the collaborating organisations. We use the qualitative data from a series of interviews with Hub stakeholder organisations to consider whether the arrangements have worked well from the viewpoint of the key organisational stakeholders and to explore views on whether it has enabled the organisations involved to meet the needs of people in B&NES. We conclude by considering the extent to which the Hub can develop a sustainable model of operations.

The performance of the Hub

During the first lockdown the Hub was staffed by a team combining Virgin Care staff, reassigned staff from B&NES, and representatives from all the involved Third Sector organisations. From April onwards there were around 10 staff working daily in a socially distanced way in the Hub facility. At the outset the Hub took calls seven days a week, between 9am and 5pm. A group of Virgin Care staff triaged the calls, dealing with 70% of cases at this point. The rest of the cases were then passed on to one or other of the nine response pods and the specialist support workers in these.

In its first weeks of operation the Hub averaged around 120 calls per day with over 200 calls on some days in its first two weeks of operation. Figure U7 shows the pattern of calls up to June 2020. As we saw in Figure U1 above, there was particularly strong usage of the Hub during the first lockdown, but this was not repeated to the same extent at the onset of the second lockdown in November 2020.

Figure U7. Pod referrals April to June 2020[14]

Hub Pod response areas of need	Date			
	Apr	May	Jun	Total
Referral area				
CCC - Health access		1		1
CCC - Social care	1	2		3
Council services		5		5
Discharge support and admissions avoidance		1	1	2
Enhanced triage	12	123	24	159
Family support		2		2
Food	32	146	30	208
General wellbeing (inc. stopping smoking and weight management)	2	6	1	9
Help from a community volunteer	93	444	83	620
Housing	2	11	2	15
Logistics and transport	19	115	14	148
Mental wellbeing	5	58	14	77
Money matters and work	13	45	12	70
Public health		5	1	6
Social prescribing		1		1
Welfare check for people shielding		15	121	136
(blank)	1			1
Total	180	980	303	1463

Source: Compassionate Community Hub: A Case for Continued Change.

A person-centric approach (client-centric) and the 'no wrong front door' philosophy

The central purpose of the Hub is that it would be a single point of contact for citizens who needed support. Rather than having to make numerous different contacts, they could then be referred-on from a central point to a range of different support services as and when required. In the interviews with organisation stakeholders this is referred to as a client-centric approach. In theory this approach is where the condition of the person

[14] There was a short time lapse between the opening of the Hub and the Riviam system starting up and as such some cases that were entered in a temporary system are probably not captured in this table.

calling is the focus of the Hub response rather than the specific issue that they call about. This also fits with the 'no wrong front door' philosophy, which argues that there should be one point of entry for those requiring support and that could be for any form of support, but it would then represent a route into further and different channels of support as required.

There are major practical advantages of these two related approaches for citizens of B&NES: it is a simple route to support, it is less time-consuming, and it should remove the need for repetition of circumstances. The Riviam system was designed as a database that would hold a common record for all callers and that the initial details could then be passed on to as many relevant support organisations as were needed.

> *One of the things it [Riviam] prevents is people having to tell their same story over and over again to different agencies, and that's a major advantage.* (Stakeholder interview)

In most of our stakeholder interviews, the opportunity presented by the Hub to continue to shift resources and partnership working towards early intervention and prevention was a key priority. A number of stakeholder organisations argued that the ability to use integrated data to map needs and to plan holistic, early support for users was a key benefit of the Hub that needed to be sustained:

> *I think it should be a joined-up approach, but it should be just all about wellbeing, keeping people well, so like preventative, rather than reactive.* (Stakeholder interview).

The key financial impacts of the Hub from early intervention and prevention for adults are likely to be in savings to acute services: supporting people to remain in their own homes, preventing admissions to acute services, and enabling effective discharges from hospital. Stakeholders recognised, however, that crystallising savings in acute care and other public services from early intervention and prevention would depend on the development of integrated data management for individuals – bringing together RDC's clinical care and referral data management systems – as well as full economic costings of user and patient pathways (described more fully in Appendix A). Many of our interviewees expressed frustration that the Riviam system had not yet been developed in these directions, and its initial promise had not yet been realised:

> *...So if you think about the customer who's got statutory need, they have to tell their story you know three, four, five, six times, and they might have dementia or a learning difficulty or a severe mental health problem. You know if Riviam truly prevented that and it was just a one-stop place where we could see all their social care records, we could see everything and they wouldn't have to repeat their story, we could see who they were working with, then blooming marvellous. But it wasn't because it was just used as a referral system.* (Stakeholder interview)

The counter pressure to the person-centric approach has been around the extent to which the Riviam system ensures data protection and confidentiality for Hub users. This has been a particular concern for RDC and is an issue that was frequently raised in the interviews and that is discussed in more detail below. It should be noted that RDC has a plan to enhance the wellbeing platform to support Shared Care Records and to provide a 'one stop place'.

The person-centric approach underpins a more joined-up approach to care. In the case of the Hub, the potential merits of a joined-up approach were particularly illustrated and to some extent facilitated by regular Multi-Disciplinary Team meetings (MDTs) held at the Hub facility. These MDTs took place every day at the start of the lockdown and were then scaled back to two-three times a week later in the period. The MDTs were referred to frequently in the stakeholder interviews and are seen by many as a significant success of the Hub.

> *At the beginning of the first lockdown we were having MDT meetings every day, at the moment [January 2021] they're twice a week, on a Monday and a Wednesday afternoon. And with that it's an opportunity for every pod to have a representative there.*
>
> *So we were having daily … multiple disciplinary … discipline meetings, MDTs, and we were literally all sat in the room together sharing these clients around. Now obviously as you can realise, that is the crux of the advantage of the Hub in terms of its effectiveness and its efficiency.*
>
> *The bit that has really worked for me is the joined up … Virgin Covid B&NES meetings [MDTs] that probably came out of that. I mean that's the bit that's been really super effective in terms of joined upness as well.* (Stakeholder interview)

The MDTs have been explained not just as a means of handling complex cases, but as an opportunity for the representatives of the different organisations to learn about and better understand each other. This understanding was explained as not only being about what each organisation could offer but also what constraints and challenges they were operating under. This experience in the Hub is also seen as having personalised a previously disjointed and impersonal system of support. It helped the staff from the different organisations put faces to names and to foster more meaningful personal relationships between the Hub workers.

Leadership

The importance of personal relationships in the functioning of the Hub during the first lockdown is particularly apparent in comments made about the leadership. The interviews convey a strong sense that the specific combination of people and personalities has been responsible for the successful working of the Hub.

> *I think we had really good relationships with our (partner) Third Sector providers anyway … and I knew XX in Virgin Care well, obviously I'm a commissioned service, so they commission us to provide lots of services, so that kind of has helped.… I've worked really closely with BANES Council but in terms of the individuals, I didn't know YY at all, so it's been fantastic getting to know her and working with her. And I think that alignment with our Virgin Care and council colleagues has been really, really beneficial, definitely.* (Stakeholder Interview)

The leading representatives from both Virgin Care and B&NES particularly are identified as having driven the speedy establishment of the Hub and then ensuring its development during the first phase of lockdown. This involved taking bold and unorthodox decisions that would normally have taken much longer to drive through the Virgin Care and local authority systems. In their leadership, however, they also drew considerably on the

foundation of relationships that had been established prior to Covid-19. They are seen as not having led autocratically, but as having generated a good team spirit in Hub.

> *YY and XX have kind of driven the Hub. But it has been … it's felt very much part … that we're part of a wider team, and we've been able to … we've been consulted and been able to take part in its development fully I feel.* (Stakeholder Interview)

The establishment and ongoing functioning of the Hub involved negotiating a complex organisational and political landscape and it appears that the effective working relationship between key people and their shared vision for the Hub was important in this.

> *(In) one meeting with XX and YY, I saw them both deal with the politics of what was happening there, they had a vision of what they wanted and they were able to just deliver that. YY was dealing with, you know into the local authority, and XX was dealing into the third sector partners and I think it worked brilliantly well. And I think that was critical to this. I think without that, it probably would have been quite difficult because they all have their own … system (and) they all have their different drivers around why … what they're doing, and I think it was critical, that leadership was really good. And also politically … it seemed to work for them that they were able to get something out of this that they wanted, as … you know of course as well as doing what they're doing. … I think they just had a very good approach with all those lead partners, and they all needed to work together. And you know that leadership between YY and XX I think was critical to the success.* (Stakeholder Interview)

Changing relationships

There was near unanimity in our interviews with stakeholder organisations that the creation of the Hub had changed relationships amongst the partner organisations. It was reported as having fostered new forms of collaboration and a cooperative ethos, in contrast to the competition that had prevailed amongst some of the partners before the Covid-19 pandemic, particularly as a result of cuts to local authority grant support:

> *I mean it's been a revelation really that actually it is possible for organisations to get away from thinking we have to retain a competitive edge over other provider organisations to … well why don't we just work together in the best interests of people who have to rely upon services?*
>
> *And I think that's a major strength of the community Hub. And long may it continue, it would be awful if it went back to the days of you know organisations working in their own separate bunkers, you know thinking you know how can we be better than the other organisations or you know how can we undercut the cost of other organisations and that sort of thing that goes on in the competitive tendering process.* (Stakeholder Interview)

The overwhelming view was that the Hub is a "*solid umbrella"*, a joined-up service that is greater than the sum of its parts. This was argued to benefit both service users and the organisations themselves. Many argued that the Hub led to better and or/faster resolution to service users' problems, enabling the providers to deal with the root causes of issues, rather than make smaller and more superficial interventions. Collaboration in the Hub is embodied in the previously mentioned, regular MDT meetings.

By providing a structure for formalised collaboration, the Hub was seen as having enabled individual organisations to expand the range of services to which they can refer service users:

> *Being involved in the Hub has meant that we've been able to tap into experts in other areas, such as addiction, homelessness, mental health, food poverty, in a way that we wouldn't have been able to have done prior.* (Stakeholder Interview)

Working together in the Hub also facilitated stronger inter-personal relationships between key individuals, which in turn led to better mutual understanding between each of the contributing organisations. The relational nature of the collaboration encouraged empathy and understanding.

> *It's transformed our relationship with Virgin Care, it's been fantastic. So we always wanted to work closely with them but you know on a personal and strategic level, the relationship between third sector and Virgin Care is much, much better, so that's a real positive. The relationship between 3SG and you know Citizens Advice, Age UK, CURO, DHI, all of that has been enhanced by us just sitting together, working together, sharing information. That has been great.* (Stakeholder Interview)

Tensions

Not all was sweetness and light, however, and there were a number of areas of tension during the first phase. One area of tension was around housing advice, homelessness and 'housing-plus' services. A number of our stakeholder interviewees argued that collaboration between the local authority, voluntary sector organisations and housing providers was already very strong before the Covid-19 pandemic, through the B&NES Homelessness Partnership and other structures:[15]

> *There was already, and this has continued alongside the work of the Hub, but there was already...a really, really strong housing and homelessness partnership in B&NES with ... with workers enmeshed and embedded and working really well together already. So we were already working in quite a partnership based way, that we have continued to do that.* (Stakeholder Interview)

This raised important questions for the Hub: would it compete for referrals with existing providers and duplicate, or even undermine, existing commissioned services? There is an extensive range of organisations in B&NES providing social housing, services for the homeless, and housing advice. Two of these organisations – DHI and CURO – provide the main housing services pod in the Hub.

DHI is a charity providing specialist drug and alcohol, social prescribing, housing advice and other services in the West of England. CURO is the primary housing association in B&NES and surrounding areas. It has 25,000 homes and provides a wide range of additional services to its tenants.

Concerns have been expressed that the existing ecosystem of housing, support and social care services may be disrupted by the Hub, but we found no evidence of such

[15] Bath & North East Somerset Council. *Homelessness Partnership*. Accessed at: https://www.bathnes.gov.uk/services/housing/housing-advice/homelessness-partnership [Last accessed 29/09/2021].

disruption in our research. In the context of significant reductions to local authority budgets and mounting pressures on NHS resources, this is ultimately a concern about security of funding flows.

The provision of housing advice services also highlights the issue of the appropriate balance between face-to-face and online or telephone services. Because of the closure of face-to-face services during the pandemic, housing advice services shifted to telephone and online access. The volume of referrals did not increase through the Hub as many of these simply replaced those that would have come through the B&NES one-stop shops. Looking ahead, interviewees suggested that this was not appropriate for all cases and that accessible face-to-face services should be restored:

> *I think the Hub is fantastic, and having a wellbeing Hub and having voluntary sector, Virgin, social care together is a model that needs to be kept and developed. What I don't think it can be is a replacement for having a multi-agency centre where people are able to access a range of services face to face, obviously Covid permitting, because what we are seeing with lots of our clients now is that the overriding need is social isolation, needing face to face contact, and the limitations of talking to someone over a phone need to be recognised...* (Stakeholder Interview)

A second area of key concern to stakeholders was the future relationship of the Hub to the health and wellbeing services commissioned or provided by the NHS. A number of the Third Sector organisations involved in the Hub were already contracted by Virgin Care for community health and wellbeing services. Others, including Citizens' Advice, are not. A number of our interviewees stressed the importance of promoting the Hub to GPs, and in future, integrating the Hub into the services planned under the new Integrated Care System (ICS) structure for the NHS and its partners in B&NES and its neighbouring local authorities.

> *I think getting the word out there to all the GPs that we exist is a really important thing. I spoke to somebody earlier from the intensive team ... complex intensive team at the [Primary Care Liaison Service] and I got the impression that he didn't ... he didn't have the number for the wellbeing Hub or for Breathing Space, which is Bath Mind's evening service. So I guess that's something that would be really handy if this is going to continue, that there's a big kind of launch out there, one for the general public, and then another one for organisations. And looking to expand what they've already done before with getting that message out.* (Stakeholder Interview)

Another argued that:

> *So what we need is the key partners to really commit to the Hub for the long term, and crucially, what it really needs is it needs to be written into the health and social care and wellbeing offer across the whole of Bath and North East Somerset. So what I'm talking about in that is that you know a lot of the time you'll go to the doctor and you might have, I don't know, high blood pressure or you might have ... you know you're not sleeping, you've got anxiety, stress or whatever, you know sometimes the solution to that isn't a medical one, it may be that you know getting the root cause of ... it might be your job, you're worried about your job, it might be your housing situation, it might be you've got no money, you know... and what we need to do is plug the social prescribing bit into the Hub,*

to get people to … to get those professionals to use it, to fully use it to its maximum potential. (Stakeholder Interview)

'Social prescribing' means referral to a range of local, non-clinical services to support an individual's health and wellbeing, usually via a link worker[16]. These are often community-based activities, such as volunteering, cookery, gardening and the arts, and advice services, for help with benefits and the management of personal finances. The NHS is expanding social prescribing across England[17] and link workers from DHI, based out of B&NES GP practices, already undertake referrals to the Hub:

A lot of our referrals recently have come from the social prescribers team. So a few months ago, we had a couple of them that came to one of the MDT meetings to introduce themself, so they're aware of our service. I think they've had good feedback about the befriending and now they're still putting in the referrals. So that's really helps because then we know what surgery you know that client is with and we can, if needed, we can contact the GP, which we have done on occasion. (Stakeholder Interview)

For some of our interviewees, expansion of social prescribing services offered the Hub a core purpose after the pandemic:

It would be better to link it up with the GPs and make it more of a social prescribing Hub, you know because otherwise the purpose is going to go and we're not going to be providing food parcels forever, and it would need some sort of driver, common purpose, wouldn't it? (Stakeholder Interview)

Others who were supportive of social prescribing nevertheless warned against the medicalisation of the Hub's services and wanted to ensure that it was kept completely distinct from clinical services:

I absolutely don't think it should become part of a clinical service. I think that would be the wrong approach. I think the reason that social prescribers work so well is that they're not clinical. You'll potentially lose sight of the impact of poor housing, the impact of … the impact of money, the impact of social isolation, which are key determinants of ill-health. And I don't think that would work. I think where we're in a good position at the moment is we have social prescribers who can be the gateway from the PCNs into the Hub services. But we also have other services, say DHI for example have shared care workers in the … in every GP surgery in B&NES, so working alongside GPs, they've also got the wider community … good community knowledge. They've possibly funding for some kind of mental health type post within GP surgeries, again voluntary sector based. And I think it's really important that we keep services rooted in the community. (Stakeholder Interview)

There were also a number of issues that resulted in confusion around food supply that illustrates tensions between the different levels of operation and governance. As noted previously, a key area of the Hub's work during the first lockdown has been food supply:

[16] Rempel, E.S., Wilson, E.N., Durrant, H., and Barnett, J., (2017). Preparing the prescription: a review of the aim and measurement of social referral programmes. *BMJ Open.* Accessed at: https://bmjopen.bmj.com/content/bmjopen/7/10/e017734.full.pdf [Last accessed 29/09/2021].

[17] NHS. *Social prescribing.* Accessed at: https://www.england.nhs.uk/personalisedcare/social-prescribing/ [Last accessed 29/09/2021].

food parcels for vulnerable people, help with shopping for those unable to leave home during the pandemic, and access to food banks for those who cannot afford to buy food for themselves. The Hub is always able to get food to someone in need: if food banks are not open, for example, the Hub can secure a food parcel delivery from B&NES. B&NES also worked with Bath Masonic Hall Trust who raised £60k and produced frozen meals for emergency food boxes as well as providing meals for local charities. The Hub collected the meals and distributed them at least three times a week from April 2020 – August 2021. Integrated working inside the Hub further allows the reasons for food poverty or food bank use to be addressed, for example, through welfare advice.

At the national government level, the Ministry of Housing, Communities and Local Government began a process at the end of March 2020 of sending out food parcels to those that who were clinically vulnerable and had been told to shield. The coordination with the local community and local government food supply arrangements did not appear to be good. As was discussed earlier, several of the clients that we interviewed had called the Hub for assistance with their food supply, but then had received the national government food parcels. In a number of the cases Hub workers had to visit clients to take away and redistribute the national food parcels.

Volunteers

This brings us to the issue of the role of volunteers both in the Hub and more generally in community-based responses to crises or to more ongoing and systemic inequalities. In organisational terms there is a significant set of questions that can be explored around the nature and extent of volunteer work in the Hub.

The subjects of 'volunteers' and so-called 'volunteer organisations' have been sensitive ones for the Hub. While the basic idea of a volunteer is that it is a person who chooses to provide their labour for no monetary remuneration, it is important to distinguish between several different kinds of volunteer involved in the Hub.

Much of the focus in the discussion of the Hub has been on the community volunteers mobilised by 3SG to carry out basic support work for clients who had been instructed to shield or who otherwise had difficulties leaving their home. These are generalist and, although they received some training, are unskilled volunteers, but there are also what can be termed the 'professional volunteers' who work for most of the Third Sector organisations involved in the partnership. For funding reasons these organisations tend to be quite dependent on volunteer workers, but their volunteers usually who have a degree of specialist expertise or experience in their field of work. These 'professional volunteers' tend to be formally contracted in one way or another; they are usually trained both in their subject and in the policies of the organisation; they are often supported by employed workers in their organisations; and (importantly)they have a defined position in relation to the information governance systems of their organisation.

For some of the Third Sector organisations involved, to be called 'a 'volunteer organisation' or part of the 'voluntary sector' is seen as devaluing their work. The use of this terminology in some of the early Hub communications was a cause for complaint from a number of the partner organisations.

> *... a letter went out to every house in B&NES and it said, you know the Hub is here for you, it's staffed by council employees and volunteers. Now that really annoyed me, because they shouldn't have put volunteers and they should have recognised*

> *... that people like me are paid third sector staff, professionals.* (Stakeholder Interview)

However, even for the generalist 3SG volunteers there are some further nuances to consider. Again, the label 'volunteer' can be seen taken as devaluing and inappropriate. The Compassionate Community philosophy conceives of these volunteers more as 'active citizens' rather than as traditional volunteers doing charitable work. As we noted earlier, the 3SG volunteers were mobilised and deployed by the Hub. 3SG see a distinction between their volunteers and any that could be mobilised through government (whether local like the B&NES CVS, or national in the form of the NHS Volunteer Responders scheme) and the 3SG emphasis is very much on community level, mutual support.

> *... it's very much the Hub offer like does stray into their (B&NES Community Engagement) territory I would imagine, but I don't really know that team very well, I ... my sort of personal view is that if we can have people helping each other, volunteers helping each other, rather than having to go through statutory providers, then that's a good thing, and the statutory providers are there if they need it and you know they're there as a bit of a back-up.* (Stakeholder Interview)

The role of 'volunteers' has been very important for the Hub and is likely to remain so in any future manifestation.

Which (whose) volunteers

This discussion raises systemic questions for the Hub about where to draw lines between support provided by volunteers or active citizens, that offered by trained advisors working in charitable and voluntary sector organisations, and the professional services offered by the statutory sector and/or its commissioned partners.

For the most part this has been clear: volunteers recruited by 3SG have provided help and assistance to people in their local neighbourhoods, after referrals from the Hub; trained advisors have provided support and advice on particular needs in the pods provided by their own organisations in the Hub; and complex cases, such as those involving safeguarding issues, have been referred onto other statutory services, where necessary and appropriate. This division of labour is reflected in the Hub's data governance: volunteers are not able to access users' data, for example. It is an issue for the future, however, as to how neighbourhood volunteers effectively articulate with a joined-up system of multi-disciplinary care and support. To what extent do they need to be aware of the complex needs of local Hub clients and how might they signal into the Hub where they become aware of more complex needs of local people that they are already interacting with?

Tensions have arisen over the existing model. As discussed above, the idea of a Compassionate Communities Hub had been developed before the pandemic and 3SG had played a leading role in that work. Due to the rapid pace of the set-up of the Hub, 3SG stepped immediately into a prominent role, making their volunteers available to the Hub. The subsequent success of 3SG and local community groups in recruiting more volunteers in the first weeks of the lockdown in 2020, and the expansion of the 3SG role through the Hub, was reported as having resulted in some friction with B&NES' Community Engagement team regarding the extent of 3SG control; questions about who should do what; the use of non 3SG volunteers; and how the Hub should be branded.

As an infrastructure body, 3SG seeks to articulate and coordinate the interests of voluntary sector organisations to statutory bodies, and to promote the independent, self-organising capabilities of the community at large; at the same time, it must work collaboratively with the statutory sector and secure the interests of its members in the grants and contracts awarded by commissioning authorities. For its part, the local authority and its partners have to fulfil their statutory obligations, while both supporting and respecting the autonomy and agency of community organisations. This necessitates negotiation over roles and responsibilities, of both volunteers and organisations – which can be the source of friction. We return to this issue in the final section of the report.

Governance and data management

In our interviews, organisational stakeholders raised issues about the governance of the Hub. Two senses of governance are important here: first, formal partnership agreements between the collaborating organisations and decision-making in the Hub; and second, information governance – with data privacy particularly a concern for RDC.

On the first, the speed of the set-up and launch of the Hub meant that there was not time to ensure formal partnership agreements between all of the partners were in place. This was being done retrospectively but gave rise to some confusions and tensions. On the second issue, in the interview with RDC it was stressed that issues of data management compliance and the privacy of clients had been a major concern for them and for the information governance teams of Virgin Care and B&NES.

At the outset of the Hub, and again because of the rapid speed of development and implementation, the user consent and information governance systems were not well established. In order to ensure that personal information was not leaked to people who had no need for it, right to see it, or who are not professionally trained to deal with it, this has been addressed in retrospective developments of the Riviam system. The increasing restriction of access to the system that RDC implemented has been regarded by some as necessary for legal data governance reasons, for other partners it has been viewed negatively and is referred to as the 'locking down' of the system. This tension between legal requirements for privacy and a user-centric, multi-dimensional approach to support is a profound and difficult tension for a multi-agency collaboration to resolve.

As one partner reflected:

> *I'm actually quite frustrated with it [the Riviam system]. I was, at one point, very much a real advocate for it, but I'm ... you know now we're 11 months in, I feel frustrated that it's not really moved on, it's quite slow. They've locked down some of the features that were useful for kind of that wider partnership working. They haven't been able to build a ... you know what's it called, an API [Application Programming Interface] between our database and Riviam, so we're still manually putting information into our database.* (Stakeholder Interview)

RDC's capacity to provide real-time data support was limited. This was partly due to the initial development of the Hub, which put in place information governance structures and implemented standard operating procedures that were sub-optimal from the point of view of providing useful operational, analytical and audit data. Some partners were complete signatories of the information governance agreement between Virgin Care and

B&NES. Other partner groups only agreed a shared standard operating procedure with respect to the data system, with a full memorandum of understanding to be completed for FY2021-22.

RDC was not contracted to Virgin Care but contracted to B&NES. The Riviam system did not integrate with any existing patient administration systems or with primary care systems and did not link to the NHS system via an NHS number. Individuals could provide their NHS number voluntarily but that did not have the capacity to link to existing NHS systems. While this was not unusual, it did limit the capacity for the Hub and RDC to provide an e-health solution that emulated a full electronic health record or a shared care record, both of which are considered important components in the provision of population health for planning, analysis and resource deployment (as noted above, there are plans to integrate the Riviam system for the Hub with existing patient admin systems and primary care systems, as part of the development of integrated care services).

The data hygiene protocols put in place for operators were essential for the functioning of the Riviam system but brought operational restrictions with them. Different partners had different procedures, which made tracking progress inconsistent across the database. While progress was trackable from the viewpoint of the Hub manager, the ability to know all partner assignments is not possible after they have been assigned to a partner, especially when that partner is not the final organisation for the individual interacting with the Hub.

Chapter 5: The Hub's systemic impact

In this section of the report, we consider the impact of wider social and political systems in B&NES on the Hub and how it may, in turn, have a systemic impact, as measured primarily by the Sustainable Development Goals (SDGs). For a discussion of the intertwined relationships between human wellbeing, resilience and sustainability and the relevance of the SDGs for this initiative, see Joseph and McGregor 2019. By 'systems' we principally mean the inter-related systems of local democracy, local economy, public services and the community. We draw on qualitative interviews with ward and parish councillors, and with stakeholder organisations.

The Hub, local democracy and community relationships

In our interviews, all bar one parish councillors seemed to have had more direct contact with the Hub than B&NES ward councillors. They spoke about referring people to the Hub, promoting the Hub (e.g., distributing flyers), knowing Hub volunteers, and liaising with the Hub about food deliveries.

Parish councillors were also much more directly involved in providing local support. Of the ward councillors we interviewed, one had been involved in the setting up of the Hub, having been engaged in pre-pandemic conversations about setting up a connected system of support in B&NES, while the others spoke about the Hub positively, but had less direct experience of it. Overall, parish councillors were able to talk about specific instances of contact with the Hub, while ward councillors tended to talk about the Hub as a 'good thing' in more abstract terms.

An interesting difference in the perspectives of ward and parish councillors – one which has systemic implications for local democracy - was their interpretation of the meaning of 'local' and what in turn this meant for the Hub. For ward Councillors, the Hub worked because it was local; to them, B&NES *was* local. This is probably a reflection of their higher-level perspective, being ward rather than parish councillors, but also seemed borne of the perception that compared to other authorities, B&NES is a tight and relatively small local authority with a strong history of providing integrated services, and of Third Sector working in partnership with the Council.

On the other hand, parish councillors had a rather different perception of local. For them, local meant their very specific local community or parish area, as opposed to the whole local authority. Where parish councillors had been involved in local voluntary initiatives, this more localised response was considered more agile and flexible than the more 'centralised' response of the Hub. For example, one parish councillor had initiated a swift local response that was later subsumed into the Hub:

> *...it was easy for me to get 250 volunteers, to divide everything up, to tell everybody what their duties were and off we went, and we did it you know ... and it was up and running in two weeks and we were meeting the needs of the community.* (Councillor Interview)

The parish council structure seems therefore to have facilitated a rapid mobilisation of volunteers and community resources, an effort which could then be integrated into the B&NES-wide structures created by 3SG, the other key charitable partners, the Council and Virgin Care. Such a rapid mobilisation of community self-help brought with it certain

problems, such as whether volunteers' activities had appropriate insurance cover or whether users' data was protected, but the local embeddedness of parish councillors, and their extensive community networks, ensured that mutual aid was rolled out quickly and effectively.

B&NES has 51 parish and town councils, although the City of Bath itself is unparished. Alongside the council's Area Forums, they provide an obvious framework through which so-called 'hyper local' volunteering and community activities can be integrated into health and wellbeing services, and, more broadly, in the development of residents' engagement in policy planning and decision-making – including through the use of digital platforms for participatory governance. This raises wider questions of the relationship between public services, local communities and the structures of local democracy that we return to in the final chapter.

Sustainable Development Goals

B&NES local authority has committed to a number of key strategies: its Corporate Strategy (2020-2024), the Bath Climate and Ecological Emergency Plan, and The Economic Review Strategy (2014-2030). Through these, the Council has simultaneously committed to the delivery of the following UN SDGs: 1 (No Poverty), 7 (Affordable and Clean Energy), 8 (Decent Work and Economic Growth), 10 (Reduced Inequalities), 11 (Sustainable Cities and Communities), 13 (Climate Action), 14 (Life Below Water), 15 (Life on Land), and 17 (Partnerships for the Goals). The Hub predominantly addresses social or socioeconomic SDGs. These include, but are not limited to, the following SDGs: 2 (No Hunger); 3 (Good Health and Wellbeing); and 5 (Gender Equality), for example.

The World Health Organisation (WHO) has recognised SDG 3 - good health and wellbeing - as a critical indicator of assessing the progress in the overall implementation of the SDGs. With this in mind, the Hub serves as a mechanism through which the Council can monitor the health and wellbeing of B&NES residents, but also, evaluate progress in tackling the SDGs holistically within the local authority area. This latter point is especially apparent when the impact of the Hub beyond matters of social policy is considered (for example, the potential of social prescribing to reduce the carbon footprint of primary care).

Various organisational stakeholders maintained that the Hub has reduced the burden on statutory healthcare. This, they suggest, has occurred firstly through the provision of tools to residents that grant them ownership over their wellbeing and secondly, through the Hub's early detection of poor health. As a result, B&NES' commitment to adopting preventative approaches to community health – outlined in the Corporate Strategy 2020-2024 – arguably becomes apparent.

A reduced burden on healthcare may assist B&NES in progressing its environmental goal of becoming carbon-neutral by 2030 by reducing patient travel and the environmental cost of treating patients. According to the King's Fund, 'the most environmentally sustainable approach to health and social care is one that minimises care miles by preventing ill health.'[18] Patient and staff travel accounts for 10% of the NHS' carbon

[18] Appleby, J., and Naylor, C., (2012). *Sustainable health and social care: Connecting environmental and financial performance*. The Kings Fund. Accessed at https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/sustainable-health-social-care-appleby-naylor-mar2012.pdf [Last accessed 28/09/2021].

footprint, while direct delivery of care accounts for 24%.[19] These statistics are particularly significant when one considers that health and social care accounts for an estimated 4-5% of England's carbon footprint.[20]

It should not be assumed, however, that the Hub automatically reduces care miles. This is a key consideration for the future of the Hub – particularly in the context of climate change action. For instance, volunteer travel may counteract any reduction in patient travel and hospital admittance that the Hub may have facilitated. In some of our interviews, it was registered that more environmentally sustainable forms of travel could be adopted by its staff and volunteers, such as electric vehicles and bikes (which have already been identified by the Council as a priority area for action in its Climate and Ecological Emergency Action Plan).

And as noted in the previous section, several interviewees envisaged the Hub becoming the single point of access for a more formal social prescribing system, through which GPs could direct patients to third sector organisations. Not only would this encourage prevention and continue to reduce the burden on healthcare, but the greater collaboration between healthcare organisations and local partners could contribute to environmental sustainability by reducing the duplication of work and wasted resources.[21]

An additional consideration for the Hub is the issue of remote working and its effect on carbon emissions. Though a number of studies have suggested home-working reduces emissions, others contend that whilst this may be true to a certain extent, it is not as straightforward as it may appear. Reduced commuting to the workplace alone does not necessarily lead to a decrease in carbon emissions; an array of additional factors must also be examined. For instance, remote workers, despite making fewer trips to the workplace, may have a more significant impact on carbon emissions than office workers as a result of increased car use for shorter trips, more frequent non-work-related journeys, and greater home energy use.[22]

The contemplation of 'virtual doors' vs 'real doors' that are geographically distributed across B&NES going forward thus becomes one of real significance. Above all, there is a need for this decision to reflect B&NES' declaration of a climate emergency, and to not unintentionally hinder the attainment of the Council's wider sustainability commitments.

'No hunger' and local food supply systems

As in the rest of England, the Covid-19 pandemic spurred the development of new structures for food supply to those in need and grassroots-led mutual aid in B&NES. In some local areas, community organisations set up 'Community Larders' to provide food with no questions asked, while across B&NES food banks expanded their activities, and

[19] Tennison, I., Roschnik, S., Ashby, B., Boyd, R., Hamilton, I., Oreszczyn, T., Owen, A., Romanello, M., Ruyssevelt, P., Sherman, J., Smith, A., Steele, K., Watts, N., and Eckelman, M., (2021). Health care's response to climate change: a carbon footprint assessment of the NHS in England. *The Lancet Planetary Health.* 5(2), pp.84-92.

[20] NHS, (2020). *Delivering a 'Net Zero' National Health Service. NHS England and NHS Improvement.* Accessed at: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf [Last accessed: 28/09/2021].

[21] Appleby and Naylor, *Sustainable health.*

[22] Dominguez, F., (2020). *Lockdown lifestyle: does working from home reduce carbon emissions?* CREEDS. Accessed at: https://www.creds.ac.uk/lockdown-lifestyle-does-working-from-home-reduce-carbon-emissions/ [Last accessed 29/09/2021].

existing food clubs and pantries run out of children's centres and libraries in towns such as Keynsham provided low-cost food to families from redistributed excess supplies:

> *We had a community response team that would go and do shopping and frozen foods and preparation foods. We had a hub, well kind of a central space in one of the shops in Keynsham, and I think … we delivered out a thousand meals, a thousand frozen meals during the period. And also we had an initiative working with Tesco and the Fareshare group… so every day we were taking out to 40 families food and things*. (Councillor Interview)

A wide and diverse range of charities and voluntary sector groups have contributed to this community effort.[23] Some 35 local organisations, schools and children's centres belong to FareShare South West, and 17 tonnes of food, equivalent to 40,000 meals, is shared in B&NES every month via the organisation. The local authority's Welfare Support team and the St John Foundation also award grants for food and white goods and make referrals to the area's foodbanks.

Anticipating many of these developments, a B&NES Food Poverty Steering Group was set up before March 2020, bringing together over 60 partners from across the local authority including St John's Foundation, 3SG, community groups, voluntary and statutory services and teams from across the council. It has developed an Action Plan for B&NES to tackle food insecurity and its root causes.[24] This provides a framework for food security policies in B&NES.

For some of our interviewees, this community mobilisation, and the coordination of community groups, charities and the local authority, prefigures the creation of new food ecosystems in B&NES, which can link together the health and wellbeing objectives of tackling food poverty, improving nutrition and reducing child obesity, with those of local food procurement and action to reduce food waste:

> *We work very closely with all those charities, providers, the food cycles, the food banks. The Food Pantries are really interesting because they've only started up since lockdown in this area. But they were … it was already planned, some of them were already planned pre-Covid and they exist in other parts of the country. They're a really interesting model because they … base themselves on using excess food waste from Fareshare, and there's a nominal fee. So as an organisation, they have to pay a nominal fee to Fareshare for this food delivery. And then all the people join and they pay a joining fee, which is around £5, depending on which one you join, and then each week you pay £2 for around £20 worth of food. So … it's very … it's very interesting because obviously it's tackling food waste as well, but that's a really good, long-term sustainable way to help people.* (Councillor Interview)

[23] These charities and community groups include Mercy in Action, Oasis, Bath City Farm, Southside Family Project, Bath Area Play Project, Food Cycle, Age UK, BEMSCA, Community at 67, Youth Connect, Square Hot Meal and Sporting Family Change.
[24] Bath & North East Somerset Council Newsroom. *How food poverty being tackled bath and north east somerset*. Accessed at: https://newsroom.bathnes.gov.uk/news/how-food-poverty-being-tackled-bath-and-north-east-somerset [Last accessed 29/09/2021].

Increasing the reach of the Hub

Finally, as noted in Chapter 3, a major challenge for the Hub is how to increase its visibility and reach in B&NES, the better to serve more of its disadvantaged and vulnerable populations. This increased reach could be achieved in part through having greater buy-in from across the different departments and teams in the local authority, but also by connecting more systematically to elements of the local health-care system. This might include integration with GPs and pharmacists. We return to these issues in the final chapter of this report.

Stakeholder organisations recognised that there were limits to how far the Hub should extend its services, however. For some interviewees, this was simply a matter of practicability: if the Hub got too large, it would become 'unwieldy'. For others, the boundaries should be set by the nature of the users' needs and whether they need professional expertise and statutory support. Adding advice on employment and skills to the pods is seen as a natural and unproblematic extension of the Hub. But other, more specialist services for those with complex needs, were not widely considered appropriate for inclusion in the Hub. For example, one stakeholder commented that it would not be appropriate to extend the Hub into specialist drug and alcohol addiction services:

> *... they know their audience, and generally their audience should be going to them, not us, otherwise it muddies the water. And you want that consistency obviously of people going to a specialist service for things like drugs and alcohol*. (Stakeholder interview)

It would also seem that the total numbers who did access support from the Hub were relatively small when considered against the levels of deprivation in the B&NES area. We have highlighted here not only the need for better awareness raising about the services that can be provided by the Hub, but also more substantial integration with other health and social care support services. Further attention would also need to be given to the issue of supporting groups of the population that are not strongly present in the Hub database, that particularly includes support for children and young adults.

Chapter 6: The future of the Hub

Our evaluation of the Hub is necessarily provisional and limited. It is based on a relatively small sample of qualitative interviews and limited data drawn from the Riviam system. We do not have longitudinal data on users of the Hub, nor the resource data necessary to undertake a full economic evaluation. With those caveats, we draw the following key conclusions from our evaluation of the Hub:

- The Hub was a successful innovation that enabled B&NES, the NHS and local voluntary and community organisations to respond rapidly and effectively to the needs of residents, particularly the most vulnerable and those shielding, when the Covid-19 pandemic swept across the UK in Spring 2020.

- Integrating access to services enables individual needs to be met quickly, holistically and efficiently. The Hub model of triage and 'pod' referral is an effective one. User satisfaction with the Hub is high.

- Although the Hub's services reached vulnerable individuals and ensured that the most disadvantaged could access support, its reach was nonetheless relatively limited. Our interviews suggest that awareness of the Hub amongst local residents was mixed. The visibility of the Hub and its services could be substantially increased. It should serve a greater proportion of the local population, particularly younger people and those with multiple needs.

- Community mobilisation of volunteers for the Hub was extensive and demonstrated a strong ethos of compassion and mutual aid in the communities of B&NES. 'Management' of volunteers was nonetheless complex and led to some tensions between the Hub's stakeholders.

- The range of services that can be accessed through the Hub is impressively wide, and there is clear value to users of the Hub in being able to access a range of services to meet personal needs. Nonetheless, there are some differences amongst the Hub's constituent organisations about how far it should extend into areas covered by strong existing partnerships or specialist services, such as drug and alcohol support. There is general agreement on deepening links with GPs and extending social prescribing through the Hub, however.

- The Hub enabled the development of stronger, more trusting relationships between its statutory and community sector stakeholders. The collaborative working it has fostered offers a platform for the provision of successful multi-agency services. A priority for future reform should be to integrate the Hub more consistently (particularly in terms of data sharing, commissioning and funding) with local NHS services.

- The governance of the Hub remains relatively under-developed and needs strengthening. Much of its success has depended on key individuals in the leadership team, and the goodwill and commitment of the stakeholder organisations. Sustainability of the Hub requires more effective, formalised governance.

- The collection, integration and analysis of data on the Hub's users all require improvement. This will be critical to the future evolution of the Hub and its integration with other local public services.

- Local political engagement with the Hub was stronger in areas with parish and town councillors. Beyond volunteering, there were limited opportunities for participatory community engagement in the development of the Hub. The relationship of the Hub and its services to the resources and 'resilience' of local communities in B&NES needs further development.

What then, of the future of the Hub? The immediate context for discussion of this issue is the recovery from the pandemic. Covid-19 has highlighted and exacerbated many of the inequalities in B&NES referred to in Chapter 1, and the recovery from the pandemic will place significant pressures on local services. The NHS faces a large backlog of patient care, both mental and physical. Schools and children's services must try to recover months of lost learning. Housing services will come under stress from increased evictions and homelessness, and demand for welfare advice and support will rise. People who have lost their jobs during the pandemic will need access to skills training and employment services.

The pandemic has also stimulated innovation and change in local communities. New forms of partnership between the statutory and voluntary sectors have developed across the UK, of which the Hub is the lead example in B&NES. New social infrastructures have developed to meet community needs, and volunteering and mutual aid have flourished. Innovations in the digital delivery of services have been embedded across the public sector. Partnership between local authorities and the NHS has secured the success of the vaccine rollout. Important lessons have been learned for future pandemic preparedness.

In B&NES, local public services and the NHS will be governed by two key strategic frameworks in the coming years: the local authority's Corporate Plan 2020-2024 (Box A) and the new Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership Integrated Care System (ICS) (Box B). Under the government's proposed new health legislation, local authorities and the NHS will have a duty to collaborate, and integrated care systems will be placed on a statutory basis. Requirements to promote competition will be removed. [25]

[25] Department of Social Health & Care, (2021). *Integration and innovation: working together to improve health and social care for all (HTML version).* Accessed at: https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version [Last accessed 29/09/2021].

Box A: B&NES Council Corporate Strategy 2020 to 2024

Preparing for the future	Delivering for local residents	Focusing on prevention
Local renewable energy	Carbon-neutral, social, and affordable housing	Local Outbreak Management Plan
High-skill economy	Energy efficient homes	Statutory health and care services
New technologies	Significant improvement of the transport infrastructure	Preventative approaches
Green local economy	Low traffic neighbourhoods	Reduce health inequalities
Walking, micro mobility (cycling), car-sharing, buses, and rail	Effective approach to fly-tipping and litter enforcement	Provision for children and young people with special educational needs and disabilities
Carbon neutral development and energy efficiency retrofitting	Citizens' Juries to improve decision making	Reduce waste, increase recycling, and support local litter picking schemes
Natural environment carbon stores and biodiversity (for example, planting more trees)	Tailor our approach to community engagement in Bath	Mental health services that build resilience, promote mental health and wellbeing and deliver the best outcomes
	Community Engagement Charter	Reduce over-reliance on residential and nursing care Build on local strengths

Source: https://beta.bathnes.gov.uk/policy-and-documents-library/corporate-strategy-2020-2024

The BSW Partnership brings together a Clinical Commissioning Group, three hospital trusts, private providers, a mental health trust, an ambulance trust and voluntary sector organisations. As an integrated care system, it spans primary, community and secondary care, and social care.

Box B: The BSW Partnership Plan for Health & Care 2020 -2024

With the shift to system-wide working, there will be changes to how health and care services are delivered. Our integrated model of health and care is the first step in that process. The model is the basis for our integrated health and care strategy. Our local population is at the centre of our model, surrounded by our different services.

• Our model starts with the individual and looks to place prevention at the heart of everything we do. We will do this through encouraging healthy living, reducing levels of smoking and alcohol consumption and encouraging weight loss

• Self-care and self-management also form a central part of the story and are underpinned by self-care technology and domiciliary care

• Primary care also plays a role through the foundation of strong, inter-connected Primary Care Networks offering a wider range of roles including clinical pharmacists, social prescribers, paramedics and physiotherapists

• Local services play an important role, including specialist services, community groups, health and wellbeing ambassadors, palliative care, rapid assessment services and mental health services being available to people near to where they live

• Wider support will also be provided by social care and mental health teams focused on adults, children and young people, palliative care and community nurses

• Our advanced practitioners and multi-disciplinary teams provide support through case management, while our ambulance service is central

• Our urgent treatment centres (UTCs), walk-in centres and minor injury units will see those who need urgent medical attention for minor health issues, freeing up accident and emergency for the most serious cases

• In our emergency departments, mental health liaison services for adults, children and young people will help to make sure people get the right care at the right time

• Finally, bed-based services, mental health support and nursing homes will provide help to those who have the greatest need for ongoing care and treatment.

Source: https://bswpartnership.nhs.uk/wp-content/uploads/BSW-Our-Plan-for-Health-and-Care-2020-2024-full-version.pdf

Each of these strategic frameworks - from the local authority and the BSW ICS - prioritises early intervention and prevention, the engagement and empowerment of communities, and integrating services to place user-centredness/individual control at their heart. Each in turn will require the deployment of new technologies, integrated data management and enhanced data analytics. Reducing inequalities and strengthening the health, wellbeing and resilience of communities are overarching objectives.

What are the implications of these strategic frameworks for the users of the Hub and the organisations involved in its operations, and for its place in the systems of local democracy, public services and local communities?

Users: Early intervention, prevention and person-centred services

The case for investing in early intervention and prevention is well established, with a strong evidence base for both individual programmes and systemic reforms.[26] Early intervention is critical to children's life chances and to adult health and wellbeing. Better prevention is also central to the fiscal challenges the NHS faces: the top 5% of patients by cost in primary and secondary care account for half of total costs, and these patients have high rates of morbidity and complex morbidity (three or more conditions). One in three patients admitted to hospital as an emergency has five or more health conditions.[27] Multimorbidity is associated with social deprivation and poor mental health, and people with multiple conditions tend to report worse experiences of care, as they commonly have to navigate fragmented, complex care and health services.[28]

There is now a widespread consensus for integrating services around individuals and shifting resources to early prevention and intervention. The recent LSE-Lancet Commission on the future of the NHS argues for 'whole systems' approaches at a local level, where the NHS 'actively contributes to cross-sector partnerships with local authorities, community and voluntary sector organisations, relevant commercial organisations, schools, and other statutory service organisations, with shared investment and benefits accrued across agencies, to influence the contexts that create poor health and wellbeing and exacerbate inequalities.' It argues for a new prevention fund, similar to a capital fund, to be invested over a decade.[29]

The Hub's model of 'no wrong front door' access to advice, care and support, holistic integration of services from the voluntary and community and statutory services, and orientation towards early intervention and prevention, is therefore underpinned by a solid evidence base and is congruent with the trend of recent public sector reforms. The existing infrastructure for the Hub could be built upon to deepen engagement with the community, bringing prevention services closer to the community, and to strengthen partnerships between charitable and voluntary sector organisations, ensuring that individuals can access a full range of advice, support and care services appropriate to their needs. As the need for emergency support recedes, the Hub will increasingly focus on holistic services – from welfare advice, to employment and skills, mental health and social prescribing - for users. Evidence on the most effective early intervention and prevention programmes - drawn from the National Institute for Clinical Excellence, academic research, and the research syntheses of the network of What Works Centres - should be utilised to inform resource allocations, within the context of a local whole

[26] See for example the Early Intervention Foundation, https://www.eif.org.uk/
[27] Department of Social Health & Care, *Integration and innovation.*
[28] Anderson, M., Pitchforth, E., Asaria, M., Brayne, C., Casadei, B., Charlesworth, A., Coulter, A., Franklin, B., Donaldson, C., Drummond, M., Dunnell, K., Foster, M., Hussey, R., Johnson, P., Johnston-Webber, C., Knapp, M., Lavery, G., Longley, G., Macleod Clark, J., Majeed, A., McKee, M., Newton, J., O'Neill, C., Raine, R., Richards, M., Sheikh, A., Smith, P., Street, A., Taylor, D., Watt, R., Whyte, M., Woods, M., McGuire, A., Mossialos, E., (2021). LSE–Lancet Commission on the future of the NHS: re-laying the foundations for an equitable and efficient health and care service after COVID-19. *The Lancet Commissions.* 397(10288), pp. 1915-1978. p.1933
[29] Ibid, pp. 1950-1954.

systems approach. To realise the maximum possible benefits to investments in prevention will require enhanced data integration and better use of data analytics.

The use of electronic patient records is increasing in primary care in the UK but remains low in social care, and data linkage remains poor. The government plans to improve data collection and data sharing in health and social care, including for those who self-fund their care. Over time, this will enable the integration of social data with NHS healthcare data, so that services can be better planned and delivered. Patients should be able to access their own secure electronic health and care records, and service providers should be able to base planning for populations on comprehensive data analytics.

It is evident from our initial evaluation of the Hub that considerable reforms are necessary to improve: (a) data collection; (b) data integration with health and social care services; (c) data for analytical use in planning and improving services, and establishing the costs and benefits of different patient pathways; and (d) enabling users to access and control their own records. We recommend that a comprehensive data strategy is drawn up for the Hub, which enables data on its users to be integrated into the wider health and social care data of the BWS Partnership. Data analytical capabilities should be strengthened in tandem.

Organisational partnership

The Hub encouraged new forms of engagement between the Third Sector and the public sector. Moreover, it promoted a learning environment, holistically aided clients by addressing root problems (rather than just symptoms) and provided significant support for overwhelmed public services at the onset of the pandemic. However, some uncertainty existed amongst some organisations concerning their roles. The information sharing system was seen – in principle, if not always in practice - as the most advantageous aspect of the Hub, allowing for a more comprehensive account of client welfare through linked records with the classification of pods being deemed effective. Furthermore, the system created an additional access point for community members in need and mitigated the loss of in-person access.

Evaluating the Hub from the point of view of administration and finance is more difficult. The Hub was ultimately created as an *ad hoc* solution to an exogenous challenge created by Covid-19. Although we have basic costings for the Hub's operations, such as for office rental, the Riviam system, and so on, we do not have full economic costings, nor the longitudinal data on user outcomes, that would enable a full cost-benefit analysis to be undertaken. Moreover, charities that are part of the Hub partner pods were identified as needing to establish a pathway to financial sustainability in the light of exogenous changes in their income streams brought about by Covid-19. Many charities are currently under financial distress and facing grant reductions (though, some have found alternative sources of income).

The Hub would thus benefit from a sustainable business model, where it provides sustainable solutions for clients and implements several key changes. A number of medium-term priorities for the Hub can be suggested. These involve: improvements in web design; a physical community centre (considerations around this are discussed further in Chapter 5); the creation of a mobile application platform (with resources, information, etc.); redirecting existing resources (e.g., volunteers and employees) to new service offerings; and developing a self-sustaining business model that directs profits back into the community and further improvements within the Hub.

Systemic reforms: Community empowerment, SDGs and climate action

In recent years, against a backdrop of substantial cuts to their funding, local authorities in England have developed new strategies for empowering their communities: establishing deliberative citizens assemblies, expanding participatory budgeting, promoting community wealth building, and fostering inclusive local economic development through procurement and community asset transfers. In addition, the pandemic triggered new forms of partnership with the Third Sector, including the mobilisation of volunteers.[30] In B&NES, existing institutions, such as parish and town councils and the vibrant Third Sector, provided a powerful platform for civic responses to the pandemic. The successful creation of the Hub, and the mobilisation of volunteers to support its services, was in large part due to the existence of this collective efficacy in B&NES.

Nonetheless, the pandemic has placed significant strains on Third Sector organisations in the UK. Fundraising activities have been curtailed while demand for services has risen. Many volunteers have experienced burnout, and the momentum generated in the early days of the pandemic has proved hard to sustain. In B&NES, the infrastructure support provided to the Third Sector by 3SG, and by the St John Foundation and others is therefore likely to prove critical in the future. Access to NHS and social care funding – via commissioned services - will also be vital for a number of organisations in B&NES.

Volunteering can make a substantial contribution to improved wellbeing for both the volunteers themselves and those they assist. A recent rapid evidence assessment on the impacts of volunteering on the subjective wellbeing of volunteers points to positive associations between the two, including improved life satisfaction, increased happiness and reduced symptoms of depression. Formal volunteering can improve the wellbeing of those from lower socio-economic groups, the unemployed, people living with chronic physical health conditions and those with lower levels of wellbeing.[31] This suggests that the promotion of volunteering opportunities to these groups in B&NES should be a priority for Third Sector organisations and the local authority. Successful social prescribing also requires an infrastructure of opportunities in the community: activities, practices and groups to which a patient can be referred.

Research into volunteering during the pandemic suggests the need to rethink volunteering or active citizenship so that the momentum behind informal volunteering and 'good neighbourliness' can be harnessed. Mutual aid group perspectives reflect the centrality of relationships and relational working. Parish and town councils, 3SG and grassroots organisations will need to consider how best to sustain the informal volunteering and mutual aid that sprang up during the pandemic.[32]

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[30] Cook, J., Thiery, H., Burchell, J., Walkley, F., Ballantyne, E., and McNeill, J., (2020). *Report #1 Lessons from lockdown.* MOVE. Accessed at: https://www.cvsce.org.uk/sites/cvsce.org.uk/files/MoVE_WP1_Report_1.pdf [Last accessed 29/09/2021].

[31] Stuart, J., Kamerāde, D., Connolly, S., Ellis Paine, A., Nichols, G., and Grotz, J., (2020). *The Impacts of Volunteering on the Subjective Wellbeing of Volunteers: A Rapid Evidence Assessment.* What Works Centre for Wellbeing and Spirit of 2012. Accessed at: https://whatworkswellbeing.org/wp-content/uploads/2020/10/Volunteer-wellbeing-technical-report-Oct2020-a.pdf [Last accessed 29/09/2021].

[32] Cook, et al, *Report #1*

As a local authority, B&NES is committed to increasing the use of citizens' deliberation and engagement through citizens' juries and other mechanisms.[33] Residents' can be involved in shaping priorities for local health and wellbeing services, including the development of the Hub, through such deliberative exercises. Although local authority budgets are now predominantly allocated to statutory social services, participatory budgeting can also be extended to discretionary capital and resource pots, perhaps through B&NES's Area Forums and the use of digital platforms.

As noted in a previous report from the IPR on the recovery from Covid-19 in B&NES, the SDGs provide a basis for designing local impact management frameworks and reporting on progress towards more inclusive and sustainable development prosperity.[34] The Hub contributes to a number of SDGs and its outcomes can be mapped onto the SDG framework.[35]

Like many local authorities, B&NES has declared climate and ecological emergencies and has set stretching targets for achieving carbon neutrality by 2030. Three strategic priorities have been identified for climate policy: energy efficiency improvement of the majority of existing buildings (domestic and non-domestic) and zero carbon new build; a major shift to mass transport, walking and cycling to reduce transport emissions; and a rapid and large-scale increase in local renewable energy generation.[36]

The Hub can contribute to climate and biodiversity goals in a number of ways. Digital and telephonic access to services via the Hub enable transport use to be minimised for those users whose needs can be met without face-to-face meetings. Better early intervention and prevention can reduce acute episodes and hospital stays, and the transport and energy costs associated with these. Increasingly, food parcel deliveries and other home visits could be made using electric vehicles or e-cargo bike transportation.[37] The Hub can also promote 'green social prescribing', linking people to nature-based interventions and activities, such as outdoor walking schemes, community gardening and food-growing projects. As the council and its partners develop a comprehensive net zero food strategy for B&NES, the Hub should become the central local source of advice and referrals.

Conversely, climate and ecological strategies provide a critical framework for promoting wellbeing. As the council's infrastructure plan acknowledges: 'There is a direct link

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[33] Bath & North East Somerset Council, *Corporate Strategy.*

[34] Copestake, J., Larkin, C., Owen, C., Hepworth, M., Waples, S., (2020). *Bath Beyond 2020: Creating a Resilient Economy Together: A Situation Report.* Institute for Policy Research and The Good Economy. Accessed at: https://www.bath.ac.uk/publications/bath-beyond-2020-creating-a-resilient-economy-together/attachments/Build-Back-Better-Report.pdf [Last accessed 29/09/2021].

[35] University of Bath MSc Management MN50583 Class of 2021. (2021) CCH Case Study Analyses. Mimeo.

[36] Bath & North East Somerset Council, (2021). *Bath & North East Somerset Climate and Ecological Emergency Action Plan.* Accessed at: https://beta.bathnes.gov.uk/sites/default/files/climate_and_nature_emergency_action_plan_for_website_v1.3_jan_2021.pdf [Last accessed 29/09/2021].

[37] For example, see Collignon, N., (2020). *Pedal Me x Lambeth Council during the Covid-19 lockdown: The logistics of delivering 10,000 care packages using e-cargo bikes.* Pedal Me. Accessed at: https://pedalme.co.uk/2020/09/08/pedal-me-x-lambeth-council/ [Last accessed 29/09/2021].

between healthy communities and sustainable development resilient to climate change... the design of new development and neighbourhoods can influence physical activity levels, travel patterns, social connectivity, mental and physical health and wellbeing outcomes.'[38] Insulating homes, reducing air pollution, promoting walking and cycling, and protecting biodiversity all contribute to community health and wellbeing.

[38] Bath & North East Somerset Council, (2020). *B&NES Draft Infrastructure Delivery Plan*. Accessed at: https://beta.bathnes.gov.uk/sites/default/files/2020-12/infrastructure_delivery_plan_dec_2020.pdf

Appendix A1.1: Model of a multicriteria analysis of the hub

This appendix presents the multicriteria analysis that has been conducted for the Compassionate Community Hub (Compassionate Wellbeing Hub) in March 2021. To ensure that decisions about the future are based on rigorous evidence, the Hub needs to be properly evaluated. Multicriteria analysis refers to an evaluation tool that can be applied to a complex decision-making process. The decision opportunity is to decide if funding should be extended and if the Hub should continue to operate as it currently does. However, it has been nearly impossible to conduct a detailed multicriteria analysis due to significant gaps and limitations in the data.

The gap analysis introduced in section 7b suggests that in order to conduct a full multicriteria analysis, staff count, staff FTEs, cost of staff FTEs - payroll/secondment/FEC, and Staff Grades and number (count/FTE) at which grade would be required. Furthermore, there are several datapoints that are missing in the data, for instance time which has been taken to resolve the case. This information would be crucial for evaluating the performance of the hub.

The main stakeholders involved in the decision whether the Hub continues to operate at the same volume are Virgin Care and B&NES Council. Other important voices in this exercise include 3SG, CURO, Age UK, Bath Mind, DHI, Citizens Advice, CleanSlate and RDC. The counter-factual alternatives to the Hub include GP services, food banks, pharmacies, mental health services/groups and accessing individual service lines through the partner organisations incorporated into the Hub (for example, money and housing advice through Citizens Advice).

It is undeniable that the objectives of the Community Wellbeing Hub can be achieved with the already existing alternatives. However, given the congregation of skillsets in the Hub, staff and volunteers are able to improve the service on offer through holistic wrap around support. And in collaborating, organisations are better placed to understand each partners' aims and objectives.

There are a number of positive externalities associated with the Hub, and with respect to speed of resolution, accessibility and adaptability, it is well placed to meet the community needs in B&NES. Early interventions by the Hub can reduce the dependency and overall costs to the health care system and can contribute to reducing the overall burden on B&NES council for adult and social care costs.

Multicriteria analysis contents

Multicriteria analysis summary form Community Wellbeing Hub - Multicriteria analysis Date: 30/06/2021 Stage: Evaluation		
Cost of Preferred Options		
Total Net Present Social Value £	Business Net Present Value £	Net cost to business per year £
What is the problem under consideration? • What does the future of the Community Wellbeing Hub look like? • Has the co-operation programme resulted in improved outcomes for service users? • Has the co-operation strengthened the organisations involved so that they are better able to contribute to meeting community needs in BANES? • Does the arrangement provide a sustainable basis for responding to systemic vulnerabilities that are generated by our current social and economic arrangements?		
What are the policy objectives of the intervention and the intended effects? • Provide assistance to those members of the community who have been made newly vulnerable by the Covid-19 pandemic. • Service lines: medication delivery, food delivery, wellbeing advice (physical and mental health), hospital discharge support/admissions avoidance, money and work advice, housing support, family support, logistics, public health advice and council services. • The effects of the Community Wellbeing Hub have been to reduce the burden on existing health and social care facilities, resolve problems quickly, adapt to complex cases and offer holistic support through a collaboration of services.		
What policy options have been considered? • Alternatives to the hub include: existing GP services, food banks, pharmacies, mental health support groups, government announced public health advice, accessing the partners individually (CURO, Age UK, Bath Mind, DHI, Citizens Advice, CleanSlate and Riviam)		
Will the policy be reviewed? It will be reviewed. Review date:		

Price Base Year 2020	Present Value Base Year 2021	Time Period Years	Net Benefit (Present Value)		
			Low:	High:	Best Estimate:

Costs	Total Transition	Average Annual	Total Cost (Present Value)
Low			
High			
Best Estimate			

Description of key monetised costs by 'main affected groups':

- Rent, building costs, service charges, general rates, water/sewage, gas, electric, maintenance, repairs, cleaning, waste disposal
- Insurance
- Internet
- Riviam services
- Bank staff
- Telephony (licenses)
- Travel
- Catering.

Other key non-monetised costs by 'main affected groups':

- No additional staffing requirements (covered by existing contracts)
- The triage centre uses Virgin Care infrastructure and call centre licenses
- The hub will support the Council in cost pressures around purchasing budget by providing a coordinated response and support to cases coming to the panel.

Key assumptions:

- Variable costs for telephony outbound calls increase subject to lockdown
- IT systems and telephony cost held by Council (thus the VAT can be recovered)
- Additional bank enhancements for weekend working can be covered through 'Covid Recovery Plan'
- Additional food supplies can be provided to the hub for distribution
- All organisations bring their own devices to keep utilities costs low
- Building costs are within the rent payable to Dorothy House
- Provision may be required for depreciation on assets
- No further costs are required for Red Centric licenses (which are the call centre phones provided to the triage team)
- Service charges are the same as Dorothy House charges
- No provision required for dilapidations over the 18-month period
- Pledged funding from lottery sources and St Johns is delivered.

Stakeholder interests, decision framework, alternatives matrix, weighting and scoring

Stakeholder Interests:
Clients

- Respond quickly to requests
- Maintain accessibility
- Advise on multi-faceted cases and offer flexibility to users with a range of concerns
- Reduce loneliness
- Ease anxiety
- Improve the transition from hospital to home after discharge
- Support complex cases
- Improve satisfaction, wellbeing and health

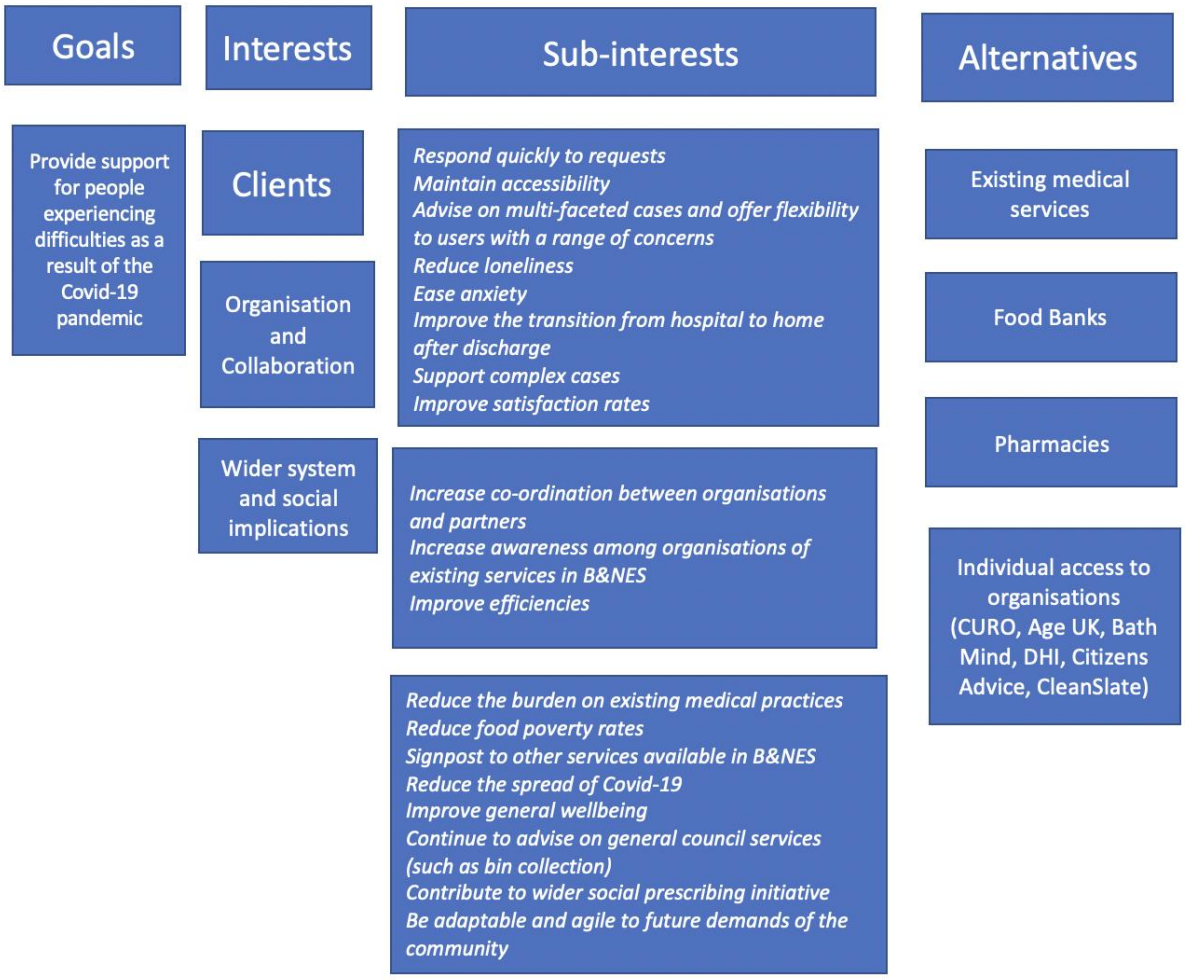
Organisation and Collaboration

- Increase co-ordination between organisations and partners
- Increase awareness among organisations of existing services in B&NES
- Improve efficiencies

Wider system and social implications

- Reduce the burden on existing medical practices
- Reduce food poverty rates
- Signpost to other services available in B&NES
- Reduce the spread of Covid-19
- Improve general wellbeing
- Continue to advise on general council services (such as bin collection)
- Contribute to wider social prescribing initiative
- Be adaptable and agile to future demands of the community

Decision framework



Alternatives matrix – how well do the alternatives satisfy the interests outlined in the decision matrix?

Using an ordinal scale (5=excellent, 4=good, 3=satisfactory, 2=below average, 1=poor)

Interest	Existing medical services	Food Banks	Pharmacies	Use of individual organisations
Respond quickly to requests	4	5	5	5
Be accessible	5	5	5	5
Advise on multi-faceted cases and offer flexibility	3	2	4	4
Reduce loneliness	4	1	1	4
Ease anxiety	5	4	5	4
Improve the transition from hospital to home after discharge	3	1	1	3
Support complex cases	4	1	4	4
Improve satisfaction, wellbeing and health	5	4	5	4
Increase co-ordination between organisations and partners	2	1	1	1
Increase awareness among organisations of existing services in B&NES	2	1	2	1
Increase efficiencies	3	4	4	3
Reduce the burden on existing medical practices	N/A	2	5	4
Reduce food poverty rates	2	5	1	4
Signpost to other services available in B&NES	4	4	3	4

Reduce the spread of Covid-19	5	2	3	3
Improve general wellbeing	5	5	5	5
Advise on council services	2	2	1	3
Contribute to social prescribing agenda	4	1	1	3
Adapt to future demands of the community	4	4	3	3

Weighting and scoring

Weightings have been assigned at random and should reflect the preferences of the decision makers.

		Rating				Score			
Interest	Weighting	EMS	FB	P	ID	EMS	FB	P	ID
Respond quickly to requests	50	4	5	5	5	200	250	250	250
Be accessible	50	5	5	5	5	250	250	250	250
Advise on multi-faceted cases and offer flexibility	45	3	2	4	4	135	90	180	180
Reduce loneliness	35	4	1	1	4	140	35	35	140
Ease anxiety	40	5	4	5	4	200	160	200	160
Improve the transition from hospital to home after discharge	20	3	1	1	3	60	20	20	60
Support complex cases	40	4	1	4	4	160	40	160	160
Improve satisfaction, wellbeing and health	50	5	4	5	4	250	200	250	200
Increase co-ordination between organisations and partners	20	2	1	1	1	40	20	20	20
Increase awareness among organisations of existing services in B&NES	10	2	1	2	1	20	10	20	10
Increase efficiencies	15	3	4	4	3	45	60	60	45
Reduce the burden on existing medical practices	30	N/A	2	5	4	N/A	60	150	120
Reduce food poverty rates	20	2	5	1	4	40	100	20	80
Signpost to other services available in B&NES	15	4	4	3	4	60	60	45	60

Reduce the spread of Covid-19	30	5	2	3	3	150	60	90	90
Improve general wellbeing	30	5	5	5	5	150	150	150	150
Advise on council services	15	2	2	1	3	30	30	15	45
Contribute to social prescribing agenda	20	4	1	1	3	80	20	20	60
Adapt to future demands of the community	20	4	4	3	3	80	80	60	60
Totals						1645	1695	1995	2140

Appendix A1.2: Desk research on integrated community/primary care health models and assessments

Optimising care pathway for the vulnerable

The Community Wellbeing Hub can be defined as an integrated care model with a people-centred approach. There is no universally agreed definition of integrated care and lack of clearly targeted aims for integrated care has made challenges for the development and delivery of integrated care.[39]

Shaw et al. treat integrated care as a two-dimensional concept and define integration as a combination of processes and services that are used to create better services for a defined group of patients, and integrated care as the desired outcome as improved care for patients.[40] In the United Kingdom, according to the description of Professor Sir Chris Ham, integrated care would mean NHS organisations, local authorities and the third sector working together to meet the needs of their local population.[41]

Integrated care models frequently combine primary, secondary and tertiary care services to meet patients' needs, make their waiting time for care shorter and increase the quality of care and patients' satisfaction. Frequently, policy objectives of integrated care are to minimise the number of patients that receive tertiary care. Professor Ham suggests that most ambitious integrated care models aim to tackle the causes of illness and the determinants of health in the population.[42] These objectives can be met with careful operational design.

For example, a system of integrated care in Canterbury, New Zealand, which is a community-based acute care model, has been carefully designed to meet the needs of local population. McGeoch et al. state that, using a combination of community-based care and education, acute medical admissions have decreased to a very low level of 18 years.[43] In some cases, the care system has resulted in shorter lengths in hospital stay among elderly patients that have chronic illness.

Canterbury's integrated care model has been designed around the results of a pivot study, which was organised by a group of local general practices. The results of the study

[39] Department of Health, Department for Communities and Local Government and NHS England, (2017). *Health and social care integration.* Accessed at: https://www.basw.co.uk/system/files/resources/basw_54210-5_0.pdf [Last accessed 29/09/2021].
[40] Shaw, S., Rosen, R., Rumbold, B., (2011). *What is integrated care?* Nuffield Trust. Accessed at: https://www.nuffieldtrust.org.uk/files/2017-01/what-is-integrated-care-report-web-final.pdf [Last accessed: 28/09/2021].
[41] The Kings Fund, (2018). *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England*. Accessed at: https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems [Last accessed 29/09/2021]
[42] Ibid.
[43] McGeoch, G., Shand, B., Gullery, C., Hamilton, G., and Reid, M., (2019). Hospital avoidance: an integrated community system to reduce acute hospital demand. *Primary Health Care Research & Development*. 20. Accessed at: https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/hospital-avoidance-an-integrated-community-system-to-reduce-acute-hospital-demand/D1216A016D66E72DD4459DF8D82E4270 [Last accessed 28/09/2021].

suggested that there is variability in referral patterns and admission behaviour for acute care, which might be modifiable by a community-based treatment and diagnostic services and locally targeted training and funding. As a consequence, the integrated care model was designed around the aim of reducing acute care admission in the area.

Assessments of existing integrated care models, such as the Canterbury integrated care model, suggest that provision of integrated health systems might have a positive impact on the population-based outcome. In Canterbury, an integrated and person-centred health system has demonstrated measurable reductions in demand for hospital and long-term care services.[44] However, some integrated health care systems have had ambivalent impact, such as the Partnership for Older People Projects interventions in the UK, whose aims for reducing costs and avoiding unplanned admissions to hospitals were not realised.[45] Similarly, Baxter et al. note that adoption of an integrated care system is very unlikely to lead to reduced healthcare costs.[46]

Providing integrated health and social care for all England is the NHS's long-term plan. However, optimising the care pathway for vulnerable groups may be challenging. The care pathway concept refers to organisation of the care process for a well-defined group of people, and its aim is often to improve the quality of care, increase patient satisfaction and the safety of patients, optimising the resources used for care in the process.[47] One successful integrated care model cannot be scaled up to other areas because all local areas have their own unique challenges. This should be taken into account when designing integrated care services because, as The National Academy of Sciences noted, one-size-fits-for-all approach may not be feasible.[48] Also Ahmed et al. emphasise the importance of considering contextual differences before implementing the same models in different locations.[49]

[44] Gullery, C., and Hamilton, G., (2015). Towards integrated person-centred healthcare - the Canterbury journey. *Future hospital journal.* 2(2), pp. 111–116.
[45] Steventon, A., Bardsley, M., Billings, J., Georghiou, T., and Lewis, G., (2011). *An evaluation of the impact of community-based interventions on hospital use – A case study of eight Partnership for Older People Projects (POPP).* Nuffield Trust. Accessed at: https://www.nuffieldtrust.org.uk/files/2017-01/evaluation-community-based-interventions-hospital-use-report-web-final.pdf [Last accessed 29/09/2021].
[46] Baxter, S., Johnson, M., Chambers, D., Sutton, A., Goyder, E., and Booth, A., (2018). The effects of integrated care: a systematic review of UK and international evidence. *BMC Health Services Research*. 18(350), Accessed at: https://doi.org/10.1186/s12913-018-3161-3 [Last accessed 28/09/2021].
[47] Schrijvers, G., Hoorn, A.,V., and Huiskes, N., (2012). The care pathaway: concepts and theories: an introduction. *International Journal of Integrated Care.* 12(6). Accessed at: http://doi.org/10.5334/ijic.812 [Last accessed: 28/09/2021].
[48] National Academies of Sciences, Engineering, and Medicine, (2019). *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. The National Academies Press. Accessed at: https://doi.org/10.17226/25467 [Last accessed 28/09/2021].
[49] Ahmed, F., Mays, N., Ahmed, N., Bisognano, M., and Gottlieb, G., (2015). Can the Accountable Care Organization model facilitate integrated care in England? *Journal of Health Services Research & Policy*. 20(4), pp. 261–264.

Developments of integrated care have taken different forms in different places in the UK. For example, the Care Quality Commission presents the following examples of successfully integrated social and health care, which operated alongside NHS.[50]

Surrey carers prescription service provided an online support service for GPs to connect with carers and the "community connector" services, established by the British Red-Cross and Co-op, and help people at risk of loneliness. The Dementia connect service, which was piloted in some areas of the UK, offered free-of-charge support from professionals that helped the patients to stay connected to their communities and navigate different social and health services.

Robertson and Ewbank evaluate three different but successful case studies of clinical commissioning groups (CCGs) that have adopted a collaborative approach for health and social services: South Tyneside; Tameside and Glossop, and Bradford district and Craven.[51] All these three CCGs are working with partners such as other CCGs, the local authority and providers to address local needs. Similarly to the Community Wellbeing Hub, these three CCGs are developing a new approach to their local health economies.

Baxter et al. identify three main outcomes from integrated social and health care models based on their extensive systematic literature review on studies in the UK.[52] First, there is strong evidence suggesting that integrated care increases the satisfaction of patients; second, the integrated care increases the quality of care compared to previous models separating health and social care. Lastly, the integrated care model improves the patient access to the care. However, it is unclear whether integration of social and health care would reduce the cost of care.

This brings us to our main question: how should one design optimal care pathways that would lead to good outcomes? According to Baxter et al., the starting point of optimising the care pathway would be defining the preferable outcome.[53] Would it be reducing the cost of the care or increasing the patient access and patient satisfaction for care? It is also more than important that the care pathway would come as majority of the models included in their study are complex and multi-element interventions, containing typically four to six elements. These models can be difficult to implement as such to other areas in order to achieve similar positive outcomes as mentioned above. Nonetheless, there are several key elements of a successfully integrated social and health care model, which are worthy to notice.

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[50] Care Quality Commission, (2020). *The state of health care and adult social care in England 2019/20*. Accessed at: https://www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf [Last accessed 30/09/2021].

[51] Robertson, R., Gregory, S. and Jabbal, J., (2020). *The social care and health systems in nine countries. Background paper of the Commission on the Future of Health and Social Care in England.* The Kings Fund. Accessed at: https://www.kingsfund.org.uk/sites/default/files/media/commission-background-paper-social-care-health-system-other-countries.pdf [Last accessed: 28/09/2021].

[52] Baxter, S., Johnson, M., Chambers, D., Sutton, A., Goyder, E., and Booth, A., (2018). *The effects of integrated care: a systematic review of UK and international evidence.* BMC Health Services Research. 18(350), Accessed at: https://doi.org/10.1186/s12913-018-3161-3 [Last accessed 28/09/2021].

[53] Ibid.

Based on its extensive 18-month long study, the National Academy of Sciences identifies three key elements for successfully integrating health care and social care[54]: 1) trained workforce which meet the patients' needs; 2) technology innovations for health information; and 3) new financing models.

The first element - trained workforce that meet needs of the patients - refers to educated health care professionals that are appropriately staffed. It is crucial for the quality of the care that there are enough skilled workforce working with the patients. The second element suggests that health information technology could be helpful for integrating health and social care. Also, Brancati et al. find that information technology can help better with aligning resources and needs in the healthcare system.[55]

NHS Leeds Care Record is a good example of health information technology innovations that can be helpful for integrating social and health care. The Care Record is a secured digital care record, which enables clinical and care professionals to view real-time health and care information across providers and different systems. Benefiting from the digitalised care report, the patient information is complete and accessible for professionals who take care of the patient. This has led to an improved safety of patients. Similar digitalised and universalised care and health records have been launched in foreign countries, such as Finland (Omakanta) and Ireland (Carefolk).

In terms of financing integrated care, Collins identifies that in many local care systems in England, commissioners and providers of care and health services have started transitioning from "arms-length" contracting to collaborative relationships.[56] Although these arrangements are at an early developmental stage, empirical evidence of these financing models suggest that collaborative partnerships have several benefits, such as improved allocation of resources where they are mostly needed. However, in some cases, collaborative partnership might not be realistic.

The three key elements are based on five so-called health care sector activities that have been identified by the committee of the National Academy of Sciences. These five activities are helpful for better integration of social and health care services, and they are *adjustment*, *assistance, alignment, advocacy and awareness*. Adjustment and assistance activities focus on improving care delivery provided for patients based on their social risk and protective factors, and alignment and advocacy of the ways that the health care sector can influence social care resources in the community. The fifth activity, awareness of individual and community-level socioeconomic risks, plays an important role in delivering the care. To conclude, the analysis of the National Academy of Sciences suggests that adaptation of these five activities can both strengthen social care integration and improve the health outcomes of social care.[57]

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[54] National Academies of Sciences, *Integrating Social Care.*
[55] Brancati, C., Kucsera, C. and Misuraca, G., (2017). ICT-enabled social innovation for active and healthy ageing – redesigning long-term care and independent living in Europe. *JRC Insights Social innovation series*. September/October. Accessed at: https://ec.europa.eu/jrc/sites/jrcsh/files/jrc107828.pdf [Last accessed 28/09/2021].
[56] Collins, B., (2019). *Payments and contracting for integrated care – The false promise of the self-improving health system.* The King's Fund. Accessed at: https://www.kingsfund.org.uk/sites/default/files/2019-03/payments-and-contracting-for-integrated-care.pdf [Last accessed 28/09/2021].
[57] National Academies of Sciences, *Integrating Social Care.*

In addition, the National Academy of Sciences suggests five goals for better integration of healthcare and social care services:[58]

1. Using the five care system activities mentioned above to design health care delivery to integrate social care into health care.
2. Building workforce for integrating social care into health care delivery.
3. Developing a digital infrastructure that can help integrating social and health care.
4. Financing the integration of health care and social care.
5. Funding, conducting and translating research and evaluation on the effectiveness and implementation of social care practices in health care settings.

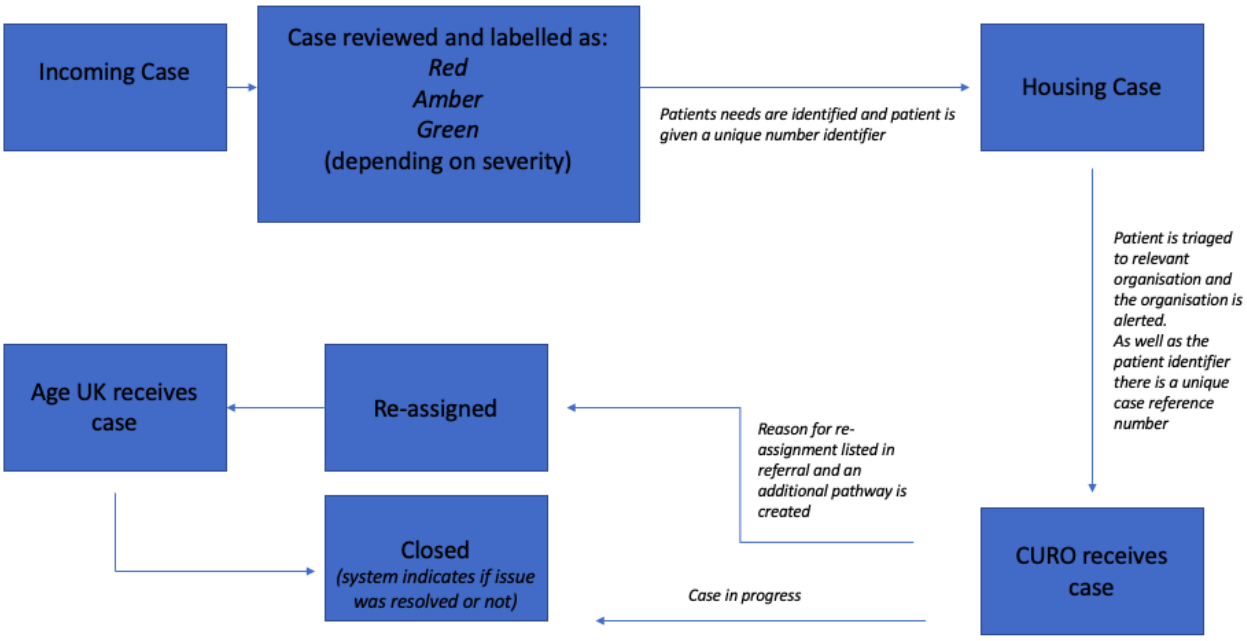
Robertson and Ewbank find that local systems need to invest in developing relationships between commissioners, because the collaboration is mainly dependent on them.[59] The three case studies show that a local and collaborative approach for social and health care can bring several benefits, such as improved decision-making, reduced running costs and combined efforts of different stakeholders to tackle local health challenges instead of competing for customers.

[58] Ibid.
[59] Robertson, et al, *The social care and health systems*.

Pathway

Flow Chart Example

These actions are stored chronologically in Riviam.



Total costs

March 2020 – October 2020

	Running Cost	
Item	Monthly Cost (excl VAT) (£)	Monthly Cost (incl VAT) (£)
Rent payable	3333	4000
Internet network	600	600
RIVIAM – Core Record	1500	1800
RIVIAM – Service referral forms (web access)	1000	1200
RIVIAM – Workflow access for all third sector organisations	2500	3000
Telephone integration (phones and video calls within system for all)	2000	2400
Bank staff	3000	3000
Telephony	1600	1920
Redcentric Licenses	-	-
Building running costs (printing, etc)	700	840
Service Charge	714	857
General Rates	-	-
Water/Sewerage Rates	35	35
Gas	158	158
Electric	205	205
Planned Maintenance & Repairs	39	39

Repairs & Renewals	47	47
General Cleaning	93	93
Window Cleaning	26	26
Waste Disposal	71	71
Buildings Insurance	29	29
Additional cost for October to continue current license for building	-	-
TOTAL	£17,650	£20,320

Costing Projections for 2021/2022

ITEM	MONTHLY COST	Total monthly cost ongoing (incl VAT)	Total cost FY20/21 (Exc VAT)	Total cost projection FY20/21	TOTAL 2021-2022 COST (exc VAT)	Total cost projection FY21/22	NOTES
Rent Payable	£ 3,333	£ 4,000	£ 19,999.98	£ 24,000	£ 40,000	£ 48,000	Currently we pay 7,000 PCM to Dorothy House to sub-lease the building in full including all service charges. The monthly charges in BAU assume that D House levels of utilisation in services is maintained. Requires landlord consent. Indication this is accepted
Internet network costs	£ 400	£ 480	£ 2,400.00	£ 2,400	£ 4,800	£ 4,800	
RIVIAM Core Record	£ 1,500	£ 1,800	£ 9,000.00	£ 9,000	£ 18,000	£ 18,000	RIVIAM current contract with Council until end Sept figures from Oct
RIVIAM Service referral form to all third sector orgs and web	£ 1,000	£ 1,200	£ 6,000.00	£ 6,000	£ 12,000	£ 12,000	

referral access							
RIVIAM workflow, access for all third sector orgs on service	£ 2,500	£ 3,000	£ 15,000.00	£ 15,000	£ 30,000	£ 30,000	
Contact telephony integration, phones and video calling within system for all	£ 2,000	£ 2,400	£ 12,000.00	£ 12,000	£ 24,000	£ 24,000	
Bank Staff	£ 110	£ 110	£ 660.00	£ 660	£ -		Very small provision for Bank in year for additional hours
Telephony	£ 500	£ 600	£ 3,000.00	£ 3,000	£ 6,000	£ 7,200	Assumes cost of calls only and use of soft phones. Gradwell contract with Council so VAT recovered
Redcentric Licences		£ -	£ -	£ -	£ -	£ -	Assumes VC do not charge for licenses as redistribute existing

Building running costs (printing, etc)	£ 200	£ 200	£ 1,200.00	£ 1,440	£ 2,400	£ 2,400	Budget to cover printing, supplies etc
Service Charge	£ 81	£ 81	£ 486.00	£ 583	£ 972	£ 972	Confirmed by DH
General Rates	£ 487	£ 487	£ 2,922.00	£ 2,922	£ 5,844	£ 5,844	Confirmed by DH but Charity - although comparable to Unit 2 opposite (occupied by VCL)
Water\Sewerage Rates	£ 35	£ 35	£ 210.00	£ 210	£ 420	£ 420	Taken from DH (current landlord) actuals
Gas	£ 158	£ 158	£ 948.00	£ 948	£ 1,896	£ 1,896	Taken from DH (current landlord) actuals
Electric	£ 205	£ 205	£ 1,230.00	£ 1,230	£ 2,460	£ 2,460	Taken from DH (current landlord) actuals
Planned Maintenance & Repairs	£ 39	£ 39	£ 234.00	£ 234	£ 468	£ 468	Taken from DH (current landlord) actuals
Repairs & Renewals	£ 48	£ 48	£ 288.00	£ 288	£ 576	£ 576	Taken from DH (current landlord) actuals

General Cleaning	£ 1,040	£ 1,230	£ 6,240.00	£ 7,488	£ 12,480	£ 14,760	Assumes that we are able to cut cleaning costs by 30% from Oct and cut lunch cleaning
Window Cleaning	£ 26	£ 26	£ 156.00	£ 156	£ 312	£ 312	Taken from DH (current landlord) actuals
Waste Disposal	£ 71	£ 71	£ 426.00	£ 426	£ 852	£ 852	Taken from DH (current landlord) actuals
Buildings Insurance	£ 29	£ 29	£ 174.00	£ 174	£ 348	£ 348	Taken from DH (current landlord) actuals
Additional cost for Oct to continue with current license for building			£ 1,200	£ 1,200		£ -	
TOTAL	**£ 13,762**	**£ 16,199**	**£ 83,774**	**£ 89,359**	**£ 163,838**	**£ 175,308**	

One off costs	Cost (excl VAT)
2 days @ 650 per day to permanently move IMT and infrastructure	£ 1,300
Cost of transferring lease (M&R) to VC	£ 3,500
Change of signage, alarm transfer and buildings info	£ 1,800
Fixtures and fittings (desks, furniture etc)	£ 5000-8000
Total	£6600 (+5000-8000)

Staff count

The majority of staff at the Hub have not been funded separately but through existing contracts. The staff work through commissioned contracts and follow redistribution under the direction of Virgin Care.

		Whole Time Equivalent	Volunteers
1	Triage	4.5	
2	Food	1.7	
3	Wellbeing (Smoking, diabetes, weight management, general)	2.7	
4	Mental health wellbeing	1.7	
5	Money matters and work	2	
6	Housing	1	
7	Logistics	5	5
8	Hospital discharge and administration		
9	Public Health Advice (COVID-19)		
10	Family Support		
11	Community Connectors (volunteers – shopping, medication, befriending)	2	17
12	Banes Council Services		

	A	B
Total	20.6	22

Grand Total	A+B	42.6

Approximating average pay grades

- Triage staff would be equivalent to NHS band 3
- Mental health staff would be equivalent to NHS band 3
- Housing staff would be equivalent to NHS band 3
- Food staff would be equivalent to NHS band 5
- Wellbeing staff would be equivalent to NHS band 5
- Banes Council Services are subject to huge variation.
- Volunteers are renumerated 40k per annum approximately (only employed physically for 6 months of the year)

NHS Pay Values

Band	Years of experience	2018/19	2019/20	2020/21
Band 1	< 1 year	£17,460	£17,652	£18,005
	1+ years	£17,460	£17,652	£18,005
Band 2	< 1 year	£17,460	£17,652	£18,005
	1-2 years	£17,460	£17,652	£18,005
	2-3 years	£17,460	£17,652	£19,337
	3-4 years	£17,460	£17,652	£19,337
	4-5 years	£17,460	£17,652	£19,337
	5-6 years	£17,787	£17,983	£19,337
	6+ years	£18,702	£19,020	£19,337
Band 3	< 1 year	£17,787	£18,813	£19,737
	1-2 years	£17,787	£18,813	£19,737
	2-3 years	£18,429	£18,813	£21,142
	3-4 years	£18,608	£18,813	£21,142
	4-5 years	£19,122	£19,332	£21,142

	5-6 years	£19,700	£19,917	£21,142
	6+ years	£20,448	£20,795	£21,142
Band 4	< 1 year	£20,150	£21,089	£21,892
	1-2 years	£20,150	£21,089	£21,892
	2-3 years	£20,859	£21,089	£21,892
	3-4 years	£21,582	£21,819	£24,157
	4-5 years	£22,238	£22,482	£24,157
	5-6 years	£22,460	£22,707	£24,157
	6+ years	£23,363	£23,761	£24,157
Band 5	< 1 year	£23,023	£24,214	£24,907
	1-2 years	£23,023	£24,214	£24,907
	2-3 years	£23,951	£24,214	£26,970
	3-4 years	£24,915	£26,220	£26,970
	4-5 years	£25,934	£26,220	£27,416
	5-6 years	£26,963	£27,260	£27,416
	6-7 years	£28,050	£28,358	£30,615
	7+ years	£29,608	£30,112	£30,615

For an ideal multicriteria analysis, the following information would be required in full:

- Staff Count
- Staff FTEs
- Cost of staff FTEs - payroll/secondment/FEC
- Staff Grades and number (count/FTE) at which grade

Key Performance Indicators (KPIs)

Building on relevant BT KPIs (2 operational and 3 financial):

Operational:

- Improvement in customer service, measured using Group Net Promoter Score (NPS) 'Keeping Our Promises'
- Total number of connections

Financial:

- Change in adjusted revenue
- Adjusted earnings per share
- Normalised free cash flow

Other Suggested KPIs:

Financial:

- Economic Value Added
- Contribution margin
- Transactions error rate

Healthcare:

- Needs and concerns met subject to the following services:
- Loneliness, medication collection, delivering/accessing food, stopping smoking, achieving a health weight and keeping active

Call Centre:

- Call completion rate
- Agent utilisation
- First call resolution rate
- Waiting times
- Average length of call
- Repeat callers
- Answer seizure ratio (% of phone calls answered, measures network quality and call success rates in telecommunications)
- Speed of answer
- Call handling time
- Call drop rate
- First contact resolution rate

Support:

- Agent performance
- Number of requests
- Satisfaction rates
- Talk time
- Complaints resolved
- Time to resolve complaints

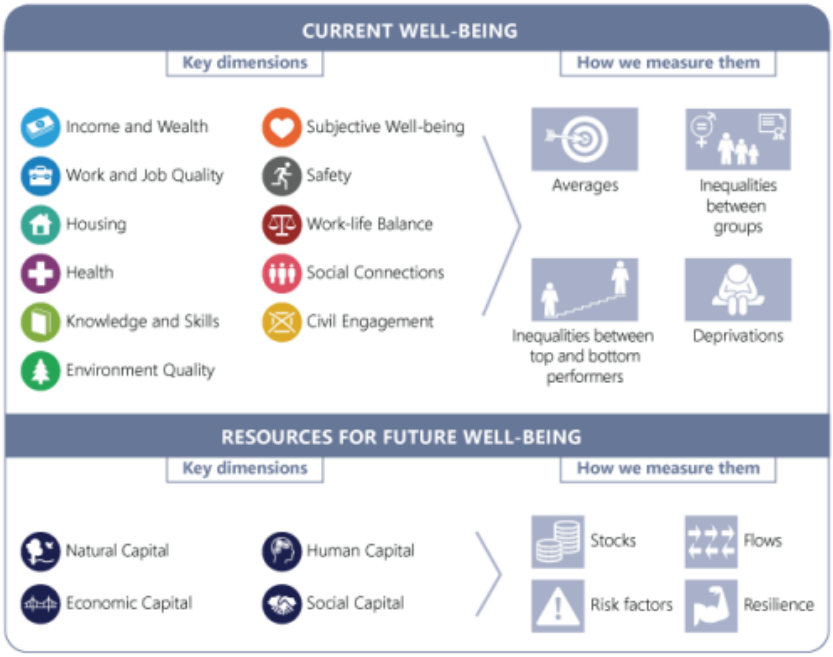
Appendix A1.3: Annex

Gap analysis of available and missing data

Data points available	Missing and required data points
System:	System:
Calls logged (time and date)	Markers to indicate complexity of case (benefit status etc)
Call referral pathway	Time taken to resolve case
Time taken for issues to be addressed	What remedy was advised?
Client information: postcode (first half) and date of birth	Most frequently used pod
Demand peaks and troughs	
Repeat patients	
Socioeconomic:	Socioeconomic:
Shielding lists	Health of population (life expectancy, fertility rates, nutrition, air pollution, obesity, physical activity, current expenditure on health, inequality, social mobility)

Dashboard of social wellbeing indicators

The OECD's 'How's Life' report included country-level data on over 80 indicators of wellbeing across the spectrum of 11 dimensions and four domains. A key strength of the framework is that many of the individual indicators are also examined for inequalities between groups, both horizontal inequalities (differences by gender, age, level of educational attainment) and vertical inequalities (differences between the top and bottom of the distribution of outcomes for that indicator). It also measures capacity for future wellbeing under four domains of capital: Economic (fixed assets), Natural (greenhouse gas emissions), Human (obesity prevalence) and Social (trust in others). The monitoring of these is key to sustainability and expansion of current living standards.



Dashboard of social wellbeing indicators. Source: OECD: Measuring wellbeing.

Potential risks to the hub

- Demand exceeding capabilities
- Digital literacy and digital accessibility
- Referral system – potential to reduce client experience (no 'one point man' per client)
- Mental health support might be enhanced with physical visits (government guidance permitting)
- Sub commissioned services unable to perform as they usually would (housing support, supported living, age related services, homelessness services, etc)
- Lack of structured feedback

Weighting methodology

Starting with a simple ranking, from most important to least important, weights were assigned firstly by allocating 100 points among the interests:

Interests	Rank	Weight
Clients	1	50
Organisation	2	20
System	3	30
		100

Weights for the sub-interests can take on any value between zero and the value of the weight given to the interest.

Annex B: Illustrative peer reforms

This appendix collates information on case studies of peer reforms to the Hub across the United Kingdom. As in B&NES, local authorities, the NHS and voluntary and community sector organisations across the country came together to initiate emergency responses to the Covid-19 pandemic – some of which drew on existing partnerships.

Like the Hub, cross-sectoral partners within these hubs utilised and strengthened collaborations between and within themselves. Although it is important to note that there are differences in how each of these hubs have functioned, valuable lessons can nevertheless be learned and adapted for the Hub in B&NES in the future.

Birmingham and Solihull – *initiated by two NHS Trusts*

The Rapid Assessment, Interface and Discharge (RAID) was first set up in 2009 by clinicians at Birmingham and Solihull Mental Health NHS Foundation Trust, in partnership with another Birmingham NHS Foundation Trust. It is a widely commended service that has transformed mental health care in Birmingham and beyond. It comprises a versatile team who assess, diagnose and manage a person's physical and psychological wellbeing, and support staff in general hospitals to ensure better outcomes of mental health cases in patients.

Research conducted by the NHS confederation and the London School of Economics and Political Science (LSE) showed that RAID led to improvements in patient care while also reducing costs by preventing unnecessary admissions, reducing length of stay and reducing readmissions. It has been expanded into other hospitals and implemented in other parts of England – for example in East London. An external review indicated that 2,800 beds had been saved in one year – largely through reduced stays for patients with dementia, substance misuse and severe mental illness.

The consideration for the effect of the service on its users and at system level was clear in its conception and planning stages. The financial, clinical, and quality impacts were all repeatedly studied – as too were the potential experiences of patients and their relatives. Similarly, the recruitment of new and existing experienced, suitable, effective and committed staff was critical for the establishment of a sustainable service model. It was equally important to align and embed all staff into the 'culture' of the service to ensure they were fully included as part of the system; without this, staff cohesion would be disjointed and the impact on patients, ineffective.

Another key feature and notable element of the service was its leadership. Favouring the division of tasks amongst staff according to the needs of patients over more traditional or hierarchical roles has allowed for equal and consistent staff development. Still, despite this success there has been resistance and challenges with operational and infrastructural constraints when attempts have been made to implement the service across a variety of trusts. This evidently presents an obstacle to encouraging similar positive outcomes in mental health care elsewhere across the country. Admittedly, there have been areas of the service which have been identified for improvement; however, it is one that still arguably merits praise.

Isle of Wight – Community Action Isle of Wight (CAIW) – *Partnership between public, private and third sector organisations*

In response to the pandemic, local hubs were set up over the island that were provided with up-to-date information on emerging policies and requirements and good practice to share on community activity, volunteer responses and other issues. The hubs provided prescription collection, shopping, hot meals, welfare calls and more. Across the Isle of Wight, residents were supported by town and parish councils and community hubs in partnership with VCS organisations.

Going forward, the council has developed a medium-term Covid-19 Recovery Plan until March 2022. It seeks to support the island's economic, community and place recovery, where the need to recover together has been identified as a necessary precondition at personal, family and organisational level. The need for even closer working partnerships between the public, private, and third sectors is perceived as being more important than ever.

On 1 May 2021, the CAIW commenced a new Future Proofing Community Resilience on the Isle of Wight project, which is to span over 18 months. It is a trauma-informed approach designed to increase community resilience, and reduce the effects of psychological trauma induced by the pandemic at an individual, interpersonal, community, and system level. The attainment of this goal is dependent upon the development of resilient individuals, families and organisations.

Community unity amidst the public health crisis in the first half of 2020 was a major takeaway from the pandemic response on the Isle of Wight. An efficient and effective network of volunteers, business, local support groups, and a general feeling of support for one another amongst all stakeholders was a notable contributing factor in this. These conditions subsequently ensured users and organisations were positively affected by the efforts of the hub and its commendable structure and thoroughly-aligned goal of ensuring community support at a time of unprecedented crisis.

North Ayrshire – *Led by local authority in partnership/with assistance of NHS and the third sector.*

Before the pandemic this locality had deepened its engagement with, and investment, in partnerships in communities and community organisations.

Services are integrated drawing on staff from the Council, Health and Social Care Partnership (HSCP), Police Scotland, Scottish Fire & Rescue and the Third Sector Interface. When the pandemic hit, localities joined up via libraries, active school staff, social work, health and social care, alongside voluntary sector organisations.

Key response areas to the pandemic included Community Hubs, which were established in a matter of days. These favoured innovation, positive risk-taking and evidence-based ways of functioning rather than bureaucratic systems. As a result, the effect of the hubs on its users was significant. The initial focus was for those shielding; however, this subsequently expanded to loneliness, mental health, daily welfare calls, and advice on a number of issues. Moreover, the presence of a wide range of partners allowed the hub to respond at pace to a high volume of requests and provide a focal point for the community response that boosted civic pride.

Since the first lockdown, this has become more of a 'virtual community hub'. However, the council has still maintained a contact centre to ensure the most vulnerable or those without access to the internet are not excluded and can still access services.

One key takeaway is the relaxation of rules that enabled Council staff to be more responsive – locality officers were given responsibility to assess risk and make decisions based on their understandings of the community.

At a system level, the hub was efficient and made important contributions. It provided important assistance to its partner stakeholders. For example, the council provided support to the NHS for patient transport to Crosshouse Hospital and supplied similar transport services for key workers and their children travelling to community and childcare hubs. The Council and Chief Executive prioritised community engagement, answering and dealing with questions and concerns from over 13,000 individuals from the community in a live Q&A session. They also ensured the council website was consistently updated, and were active on social media throughout the pandemic, experiencing significant levels of growth on these channels during the pandemic. As a result, community engagement increased.

Leeds Neighbourhood Networks (LNNs) – *Led by local authority in partnership with public, private and Third Sector organisations.*
The LLNs aim to support older people to live independently and participate in their communities as they grow older through a range of activities provided at a neighbourhood level.

They have developed over the last 30 years, and there are now 37 NNs covering the city of Leeds. Prior to the pandemic, there was a desire for there to be a collaborative relationship between the LNNs and the health and care sector. However, when the pandemic and lockdowns commenced, this ambition was placed on hold and NNs instead responded by helping with shopping, food, hot meals, delivering medicines as well as meeting social and emotional needs (welfare calls).

One 'Digital Health Hub' was established and used volunteers to train and support 55 older people to get online during lockdown. This included enabling them to access platforms such as Zoom and running virtual groups and weekly programmes of online talks, boredom busters, coffee mornings, IT classes and a range of other activities.

As the pandemic progressed, different NNs devised new ways in which they could continue to meet community needs. Some NNs played a wider role during the pandemic becoming 'community care hubs' to support a wider group – for example, younger adults, families and children, people outside their immediate geographic locality.

At the system level, the LNNs have been outwardly focused and facilitated new links with other stakeholders. For instance, there have been a number of collaborations with other partners in the area, including local community transport groups, food surplus organisations and private sector companies. Indeed, the common goal of prioritising support for local residents made vulnerable by their circumstances, was imperative for the LNNs success.

Additionally, each NN had been developed from the 'community-up.' As a result, they were able to understand the needs of its users and were deeply committed to meeting these needs.

Scarborough and District Community Hub – *Led by a Third Sector organisation in partnership with local authority and other Third Sector organisations*

In response to Covid-19, a Community Support Organisation (CSO) mechanism was established by North Yorkshire County Council and subsequent stakeholder discussion focused on the formation of a community hub. The CSO is led by Age UK Scarborough and District, with support from Scarborough, Whitby & Ryedale Mind, and YMCA Scarborough, in partnership with the North Yorkshire County and Scarborough Borough Councils.

Despite some funding concerns, the Hub has been significantly impactful – particularly in its effect on its users. It has responded flexibly and rapidly to the evolving challenges facing those in the community – particularly (but not entirely) residents who were shielding, elderly, self-employed, or suffering mental health issues. Here, a key contributing attribute is the ethos by which the Hub functions: it seeks to respond to the needs of the community rather than predetermining a list of services to provide, which may subsequently and unintentionally exclude certain groups of (prospective) hub users. This is a similar approach that has previously yielded success and received commendation in initiatives such as the Wigan Deal (see below).

As a result, positive outcomes for the physical and mental wellbeing and independence of residents have been realised. Moreover, volunteer skills, confidence and long-term commitment to volunteering have also increased. However, the biggest impact of the Hub has been its structure and its facilitation for partnership working and growth.[60] That is to say, the strength and efficiency of the Scarborough and District Community Hub's governance at system level and its subsequent impact on its third sector organisation partners has been material. The Council and VCSE sector – like other organisations within the third sector itself – have developed close and powerful working partnerships, and supported the community and local businesses in forging similar relationships amongst them.

As highlighted earlier, the Scarborough and District Community Hub's person-centred focus which relies upon consistent community input mechanisms has evidenced the need and importance of allocating more time and resources to complex cases which do not otherwise receive the attention they require and deserve.[61]

The Wigan Deal – *Led by local authority in partnership with the NHS, Third Sector and local community*

In essence, the Wigan Deal is an agreement between the Wigan Council and residents (individuals, organisations, and communities alike) to commit to, and unite to strive for, a better borough. The commitment seeks to ensure everyone continues to receive good-quality access to services regardless of background, despite the Council being required to make financial savings since 2011 as a result of central government spending cuts.

[60] Coutts, P., Ormston, H., Pennycook, L., and Thurman, B., (2020). *Pooling Together: How Community Hubs have responded to the COVID-19 Emergency. Carnegie UK Trust*. Accessed at: https://d1ssu070pg2v9i.cloudfront.net/pex/carnegie_uk_trust/2020/09/30090419/LOW-RES-4685-C19C-Community-Hubs-Case-Studies-1.pdf [Last accessed 30/09/2021].

[61] Ibid.

Though the Deal was initiated eight years prior to the pandemic, its ethos and the ways of working it engendered have been critical to the local response to Covid-19.

The Deal is an asset-based approach that recognises and nurtures the strengths of individuals and communities to subsequently promote independence and self-reliance. Additionally, it prioritises two-way conversations with residents, and brings together local services and community groups across small areas across the community (referred to as service delivery footprints) in weekly meetings. Here, representatives from the council, police, health and social care, NHS, and complex dependency team discuss cases and share information to avoid referral forms for community members and duplication of efforts across organisations/stakeholders.

Whilst Wigan Council leads the development of the agreement, its enabling style of leadership is crucial – allowing other actors to lead and have equally important roles in other areas as well, for example.[62] Moreover, voluntary and community sector organisations are seen as partners and actively supported to develop and improve. This crucially makes operations less bureaucratic. It frees up workers to take positive risks, increases engagement with the community, and decreases the bureaucratic burden of spending more time on processes and procedures that were previously ineffective.[63] More importantly, it increases stakeholder satisfaction and ensures they are all equally valued and united together in a shared ethos of serving the community. As a result, the Deal has been effective in ensuring the full utilisation of its partner organisations to ensure positive wellbeing outcomes for the local community are realised.

This is supplemented by the Deal's emphasis on investing in communities. The Wigan Deal differs from many similar peer approaches in its governance, which explicitly defines and unite all stakeholders around a common purpose and goal that drives the initiative and places community support at the forefront of its operations.

The Wigan Deal also supports social prescribing by employing community link workers in GPs.[64] The Wigan Deal has additionally placed great focus on growing citizen leadership through roles such as community health champions, dementia friends and autism friends. Though Wigan still suffers from high levels of inequality and deprivation, these efforts have collectively had a positive impact for wellbeing, and social and health care in the area since its introduction.

Renfrewshire Neighbourhood Hubs – *Partnership between local authority, HSCP and Third Sector organisations*

Located in the West of Scotland, Renfrewshire Council has a population of 179,000, and from March 2020 until August 2020 had seven neighbourhood hubs spread over three locations.[65] These were flexible; received no independent funding; relied on Council and

[62] Naylor, C., and Wellings, D., (2019). *A citizen-led approach to health and care: Lessons from the Wigan Deal*. The Kings Fund. Accessed at: https://www.kingsfund.org.uk/sites/default/files/2019-07/A%20citizen-led%20report%20final%20%2819.6.19%29.pdf [Last accessed 30/09/2021].
[63] Ibid.
[64] Ibid. See pp. 22-27 of this report for stakeholder interview debate on potential future incorporation of Hub services and social prescribing into ICS.
[65] Coutts, et al, *Pooling Together.*

volunteer resources; and ran in partnership between the Council, Health and Social Care Partnership (HSCP), and the third sector. Not all villages or small areas were targeted by these hubs, however, as many already had their own pre-existing local community groups.

Moreover, the initial stages to set up the Hub were highly efficient – with standards for the levels of volunteer recruitment, training, and support being high. Furthermore, the effect of the hubs on its users is evident. The neighbourhood hubs were successful in engaging members of the community who were both not known to have mental health issues, and those who had not previously engaged with the Council or existing health, social care or wellbeing type services. Subsequently, community satisfaction with hub services and support has been high.

Crucially, collaboration between the Council and the third sector appears to have been relatively seamless. Sentiment exists amongst both that they have strengthened their working relationship. Moreover, there is a consensus amongst those in the volunteering sector that the efforts and importance of their work has been valued. To this end, the strengths of the hubs at system level and the impact of this on its organisations/stakeholders – like the effect on its users – is similarly positive.

Still, Renfrewshire faces significant challenges in the future with volunteering. As uncertainties around levels of short to medium-term unemployment linger, the lack of an explicitly defined common goal and purpose in the post-pandemic era have caused hub partners to fear low(er) motives for individuals to volunteer.

Concerns in the future also exist surrounding the ability (or lack thereof) to mobilise services and volunteers at levels consistent during the pandemic. This can be attributed to two factors. Firstly, the return of non-emergency period risk assessments which have been seen to be synonymous with the easing of the restrictions/tail end of the pandemic. This has been observed to be an obstacle to operations return of risk formalities (and associated obstacles to operations) concerning risk assessments.

Lancaster City Council Community Hub – *Led by local authority in partnership with other public sector and Third Sector organisations*

This case study relates to Lancaster City Council, a non-metropolitan district council. When the pandemic struck, the Council swiftly restructured its operations to deliver vital services, protect vulnerable people and support businesses. There was a consensus amongst local authorities that these would be tailored to the specific needs of the community. Moreover, these priorities were devised and introduced to contribute to long-term concerns within the area, and were thus, not intended simply as short-term solutions to issues within the community catalysed by the pandemic. To this end, at the system level, the Council's strong commitment, clearly defined goal(s), and leadership meant the community hub was largely successful and had widely positive impacts on all involved stakeholders.

A significant quality of the Council and key takeaway from this case study was its perception of its staff as enablers and facilitators. Together with other local organisations such as the NHS, United Utilities, Adult Social Care, and Lancashire Fire and Rescue, the Council established a list of potentially vulnerable residents who were not initially covered under the UK government's list of the clinically vulnerable at the onset of the

pandemic in March 2020. The Council then adopted a proactive approach to protecting the wellbeing of residents within this newly established and adapted category, contacting and conducting checks with them to ensure they were cared for.

The Council also facilitated an environment that allowed for the establishment of a highly successful food delivery network. In addition, they provided critical financial and logistical assistance to Morecambe Bay Foodbank, which allowed the project to deliver some 17,000 boxes to over 5,000 households between May and July of 2020.[66]

The Hub's volunteers were referred via Hope Church, and Lancaster District Community and Voluntary Solutions (CVS) which doubled up as an effective system where residents could both request help and offer their support. By May 2020, the number of Disclosure and Barring Service (DBS) checked volunteers had already exceeded demand within the area.

The Hub generated increases in community engagement (integral to the overall crisis response to the pandemic, and the Hub's efficiency); an even closer working relationship between the public and community sectors (aided by unity around a common goal); increased practical support for businesses; and an overall reshaping of the way the Council works. Currently, Lancaster City Council and the community are jointly devising potential ways in which the capacity and engagement of the Hub can be expanded going forward.

The Lancaster City Council Hub is a key case study which arguably serves as an exemplar of efficient and effective local authority-led crisis response. Indeed, in the aftermath of Storm Desmond in 2015 the Council developed a similarly effective recovery crisis recovery plan, and has recently completed a major flood risk management scheme. In the context of the Lancaster City Council Hub, there was an important recognition that the effects on the community of the pandemic would be long-term. As a result, the Council has emphasised the need for a sustainable future for the Hub that will allow for it to continue to respond to the changing needs of residents in the district.

[66] Ibid.

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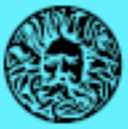

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