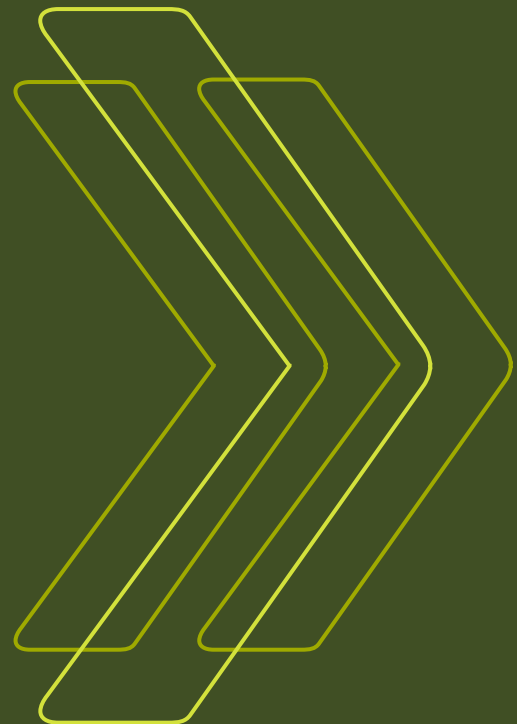


Creating healthy places

Perspectives from NHS England's
Healthy New Towns programme

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Key messages

- The places we live in have a profound impact on our health and wellbeing. Significant gains in population health can be achieved by working in partnership to improve the built, natural and social environments.
- NHS England's Healthy New Towns programme has shown how large-scale housing developments and regeneration projects can be used as an opportunity to test and deliver innovative approaches to population health and integrated care, aided by a strong focus on community development. Many of the lessons from the programme are also relevant to existing places.
- Creating healthier places requires closer working between the NHS, local authority planning teams, developers, public health professionals, voluntary sector organisations and communities themselves. In areas with two-tier local government, strong links between the NHS and district councils are important.
- The programme worked in part by acting as a connector and catalyst in local systems. Participating sites created a small team of people with an explicit responsibility for bringing partners together and facilitating dialogue across sectors. A key question is who should play this role outside of innovation programmes like Healthy New Towns.
- There needs to be concerted action on health inequalities as part of efforts to create healthy places, informed by data on the specific health needs of local communities. Health-promoting infrastructure, activities and opportunities need to be accessible to all, with a targeted focus on groups with the poorest health outcomes.
- New housing developments can be used as an opportunity to help bring about improvements in health and care for established communities in surrounding areas. Local partners should ensure that these people benefit as well as the new community.

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- Place-based interventions can be designed to improve population health and strengthen community bonds simultaneously – for example, through group-based social activities in public spaces that encourage physical activity. This can be particularly helpful in new places where the community is still becoming established, but it is also applicable elsewhere.
- New places should be seen as an opportunity to redesign primary care so that GPs are part of a wider team that includes community health services, social care, mental health services, and local voluntary and community sector organisations. New premises that bring multiple services together on one site are one way of enabling this.
- In areas where major new housing developments are planned, NHS organisations need to know how and when to engage with planning processes in order to seize opportunities to secure funding for new health care infrastructure.
- Health leaders involved in strategic planning – for example, in sustainability and transformation partnerships or integrated care systems – need to be aware of any significant housing developments in their area. They should think proactively about how their plans will make the most of these developments and take the health needs of new and existing communities into account.



1 Introduction

Health and place

The places we live in and the communities we belong to affect our health in countless ways – sometimes very visibly, sometimes more subtly, but with a significant combined effect. A coherent approach to improving population health therefore needs to include a focus on places, neighbourhoods and communities as well as interventions aimed at individuals and at the whole population ([Buck *et al* 2018](#)). The essays included in this report illustrate how powerful this principle can be when it is put into practice.

An evidence review published by Public Health England ([2017b](#)) shows how several aspects of the built and natural environment shape population health.

- Neighbourhood design (such as the layout and connectivity of streets) influences levels of physical activity among local residents.
- Housing quality affects health in various ways – for example, living in cold or damp housing increases rates of respiratory conditions and affects other health outcomes.
- The availability of affordable, healthy food in the local area is an important determinant of dietary behaviours, obesity rates and other outcomes.
- Access to nature, parks and green spaces is associated with improved mental health and reduced risk of cardiovascular disease.
- Provision of good public transport combined with infrastructure to support walking and cycling can lead to a number of health gains.
- Living in areas with poor air quality is associated with increased risk of developing various health conditions, including chronic respiratory conditions and cancer.

Creating health-promoting places also involves thinking about the social environment. The quality of our social relationships and community networks has a major impact on our health and wellbeing, as do the social norms we are



exposed to. Strong social relationships can play a protective role, with an effect on mortality risk similar in magnitude to giving up smoking (Holt-Lunstad *et al* 2010). Stressful living conditions or exposure to negative social environments – for example, where there are high levels of crime or fear of crime – can have a negative effect on both mental and physical health (Public Health England 2018, 2017a). The social environment we live in is itself shaped by the built environment, and there is evidence that good urban design can help to create places that promote social interaction and relationship-building (Public Health England 2017a; Gehl 2010; Frumkin 2003).

Within the professions associated with the built environment – planning, urban design, architecture and others – there has been a long history of concern for health. Creating places that promote health and wellbeing is often one of their implicit or even explicit objectives, with various guidance documents existing to support them in doing so (Town and Country Planning Association 2018a; Local Government Association 2016). However, there are also barriers to achieving these objectives. For example, a survey of relevant professionals found that pressure to meet housing demand can lead to the prioritisation of quantity over quality when developing new places (Hunstone *et al* 2018), making it harder for them to take an active role in ‘healthy place-making’ (see box).

What is healthy place-making?

On one level, ‘place-making’ refers simply to the planning, design and management of public spaces. However, it tends to be used to describe a broader perspective that emphasises not just the spaces themselves but how people use them, based on the belief that thriving neighbourhoods and inviting public spaces play a profoundly important role in community life (Project for Public Spaces 2016). When put into practice, the approach often places significant value on collaboration and co-design between professionals and local people.

The concept of ‘healthy place-making’ builds on this by asserting that an explicit goal of those involved in place-making should be to improve the health and wellbeing of the local population.



In recent years it has also become common for the health sector to use the term 'place' in a somewhat different but related sense. The King's Fund has argued for a place-based approach to health, meaning that the full range of public services operating across a local neighbourhood or place need to be aligned and connected in order to offer a co-ordinated, efficient service to local people and to effectively tackle the social determinants of health (Alderwick *et al* 2015; Ham and Alderwick 2015). Similarly, the NHS long-term plan (NHS England 2019b) describes how integrated care systems will need to work alongside local authorities at 'place' level to make shared decisions about how the collective resources available to the local system can be used to improve population health and deliver integrated care.

As outlined below, NHS England's Healthy New Towns programme speaks to both of these notions of place. It has attempted to create physical and social environments that promote health and wellbeing, and to ensure that residents of new places have access to integrated health and care services.

The Healthy New Towns programme

Across England there are large numbers of housing developments currently being planned or already under construction in response to the significant housing shortages seen in many parts of the country. In 2014, the *NHS five year forward view* identified this as an opportunity to test innovative approaches to health in new places with fewer constraints (NHS England *et al* 2014). The Healthy New Towns programme, delivered by NHS England in partnership with Public Health England, was established to put this vision into practice. It had three key aims:

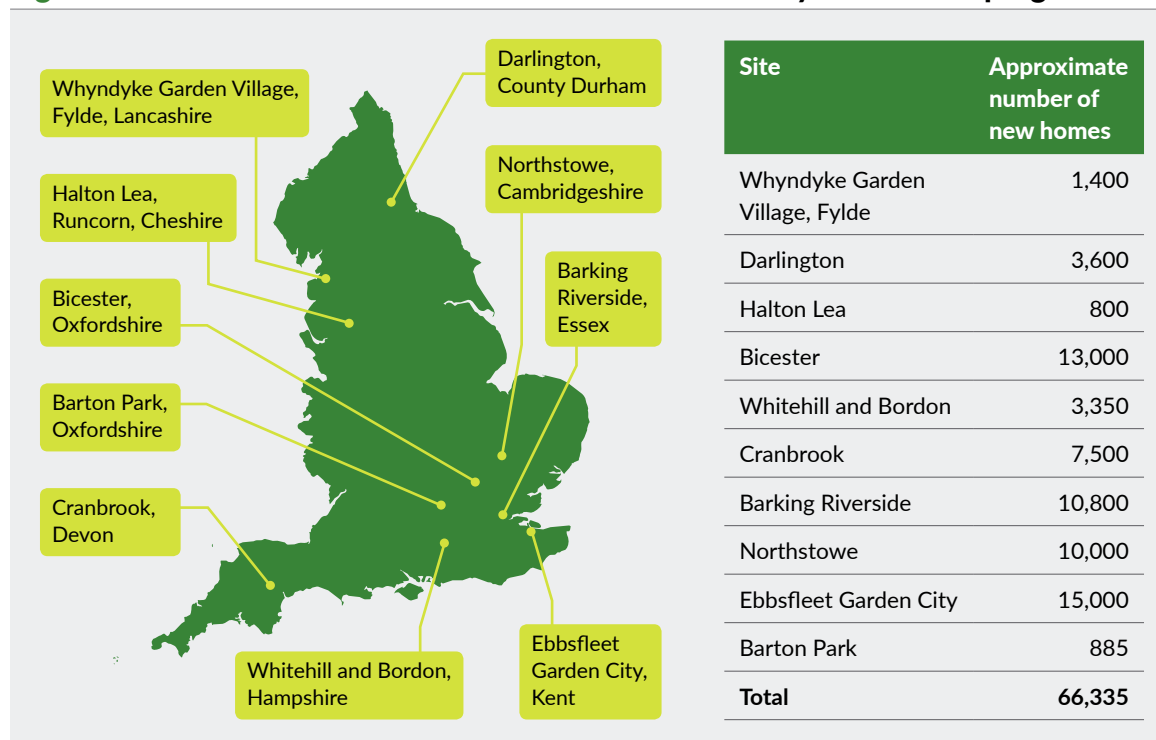
- to shape new towns, neighbourhoods and communities to promote health and wellbeing, prevent illness and keep people living independently
- to radically rethink the delivery of health and care services and to support learning about new models of integrated care
- to spread learning and good practice to future developments and regeneration areas.

Parts of the country that were planning large-scale housing developments were invited to apply to participate in the programme, and in March 2016 NHS England announced the 10 chosen 'demonstrator sites' (see Figure 1). Demonstrator sites

received funding and technical support over a three-year period ending in March 2019. Key individuals from each site took part in learning collaboratives intended to support the exchange of knowledge and expertise across all sites. These collaboratives focused on four domains:

- creating built environments that support healthy behaviours and help to promote health and wellbeing
- developing community networks and activities that support social connections, participation and empowerment
- planning and implementing innovative models of integrated care, enabled by new facilities and digital technologies
- measuring the benefits through economic analysis and evaluation.

Figure 1 The 10 demonstrator sites included in the Healthy New Towns programme





A notable feature of the programme was that demonstrator sites were expected to work across all of these domains in parallel, with a requirement that their work programmes would include a focus on the built environment, community development and integrated care. In the discussion section of this report, we argue that bringing together these three strands has created valuable opportunities to have a greater combined impact.

As with NHS England's new care models programme – also a product of the Forward View – the change model underpinning the Healthy New Towns programme was that the national programme team should set clear high-level expectations of demonstrator sites while allowing local leaders to retain autonomy and control over the detail. As we have discussed elsewhere ([Naylor and Charles 2018](#)), this represented a new approach towards catalysing large-scale change, with national NHS bodies attempting to play a facilitative rather than directive role.

In addition to the 10 demonstrator sites, the programme also established a Healthy New Towns Network, comprising housing developers and housing associations committed to implementing the learning and best practice identified through the programme within their own development and regeneration schemes.

NHS England and NHS Improvement are currently working with partners across government to develop ways to promote the principles and ensure they are adopted at scale.

Putting health into place

NHS England worked with partners (including The King's Fund, the Town and Country Planning Association and The Young Foundation) to produce a suite of guidance documents capturing learning and insights from the 10 demonstrator sites. The output from this work, *Putting health into place*, is aimed at anyone involved in the creation of new places, including planners, developers and their partners in local NHS organisations ([NHS England 2019a](#)). *Putting health into place*



is framed around 10 principles derived from the experience of the demonstrator sites, as follows.

1. Plan ahead collectively.
2. Assess local health and care needs and assets.
3. Connect, involve and empower people and communities.
4. Create compact neighbourhoods.
5. Maximise active travel.
6. Inspire and enable healthy eating.
7. Foster health in homes and buildings.
8. Enable healthy play and leisure.
9. Provide health services that help people stay well.
10. Create integrated health and wellbeing centres.

Putting health into place also provides an overview of each demonstrator site and further detail on the work conducted across them, including case studies showing how the 10 principles have been put into practice.

One of the key themes running throughout the guidance is the importance of tackling health inequalities. This is worth highlighting because there is a risk that the primary effect of creating health-promoting places is to help people who are already relatively healthy to become even more so. While this is still a positive outcome, the Healthy New Towns programme has stressed the need to ensure that population groups with poorer health outcomes benefit the most from investments in new places.



About this publication

This essay collection is intended to complement the practical lessons learned provided in *Putting health into place*. We invited a range of people involved in the Healthy New Towns programme to reflect on the key insights gained throughout its duration. Contributors were selected to include a range of perspectives, covering the following:

- the national bodies responsible for overseeing the programme (sections 2 and 3)
- organisations that acted as partners supporting the programme (sections 4 and 5)
- a range of representatives from demonstrator sites (sections 6 to 11)
- a member of the Healthy New Towns Network (section 12).

The discussion (section 13) draws together some of the main themes addressed by contributors and reflects on the lessons learnt through the programme.

It is worth noting that local work on healthy place-making in the demonstrator sites will continue despite formal support from the national programme having concluded at the end of March 2019. As such, the essays should be read as capturing the lessons to date from a process that is still under way, rather than providing a final verdict at the end of the journey. They represent the personal views of individual contributors on their own experience.



2 Why we need to focus more on healthy place-making

Duncan Selbie

Duncan Selbie is the Chief Executive of Public Health England, which worked closely with NHS England in support of the Healthy New Towns programme.

Our health is about much more than health care alone.

People in the least deprived areas live around 20 years longer in good health than those in the most deprived areas. Many things influence this; one being the environment we live in.

It is well-established that the place we call home determines the inequalities we face. The wider determinants of health have a profound impact on our wellbeing and are far-reaching, from the physical neighbourhood we live in to the community we belong to.

NHS England's Healthy New Towns programme – in partnership with Public Health England, the Town and Country Planning Association, The King's Fund and The Young Foundation – looks at how health and wellbeing can be built into new areas of housing. It has brought together partners in housebuilding, local government, health care and local communities to work together and share experiences and expertise.

Since the 19th century, public bodies have taken steps to prevent the living environment adversely affecting our health. We now take many of these measures for granted, such as providing sanitation and clean drinking water, overcoming overcrowding, protecting daylight in homes and improving air quality. In the modern age, our environment inadvertently contributes to ill health from other factors such as sedentary lifestyles, loneliness and poor diet.



In towns and cities, this can be affected by the way streets are laid out, the location of schools, shops, services, homes, workplaces and places for entertainment and recreation, and how buildings and public spaces are designed and run. During the process of planning and designing new housing, we should be asking questions about what impact all this has on people.

For example, does the environment make walking to school or work a viable, appealing option? Can young and older people cycle easily and safely around the neighbourhood? Do the shops offer affordable, fresh and healthy prepared food, or is the high street dominated by calorie-dense fast food outlets? Does everyone have access to open green spaces and are they safe, attractive and well-managed? Do people have friends living close by and know their neighbours? All these factors can influence our desire and ability to make healthier choices, and can influence our mental health by providing opportunities to socialise and access emotional support.

The NHS long-term plan has prevention at its core, and planning places that help people to be healthier speaks directly to this. For the NHS to remain sustainable, as a nation we must focus on preventing ill health and particularly those illnesses that are avoidable, such as cardiovascular disease, type 2 diabetes, and poor mental health.

Essentially, through better planning of our towns and cities, we can help people lead better lives.

While there are ways of shaping existing neighbourhoods – for example, by restricting the growth of fast food outlets in deprived areas – the Healthy New Towns programme presents an opportunity to maximise major new housing schemes from the outset, to create places that enable people to live more healthily and to help reduce health inequalities.

In practice, this means connected neighbourhoods where it is convenient to get to school, work or the shops on foot or by bike. It means places where everyone can enjoy green spaces easily and where it is easy to make friends and share a sense of purpose and belonging to the area. It means places where the health care system helps people stay well and provides joined-up services, and where schools and workplaces are set up to support the health of all those who use them.



By collaborating with the people who plan, design and manage our neighbourhoods, and by involving local people in decisions about their communities, we can shape places to fit these outcomes.

Of course, it takes many years – sometimes decades – to plan, design and build new neighbourhoods, and it can be difficult to shift established practice in any sector. But given the national housing shortage and a government commitment to continue driving the construction of new homes, the time is right to create places that make it easier for people of all ages and means to live healthily.

The Healthy New Towns programme is a brilliant, forward-thinking initiative and our hope is that it will create towns and cities in which people experience reduced levels of preventable disease; communities have improved health and wellbeing; and health and social care provision is convenient and accessible.

As part of the programme, 65,000 homes will be built or are currently in development across the 10 demonstrator sites. This is an important step in this journey and will provide opportunities to learn from their experiences, and to ensure that the homes of the future can help us all to live healthier for longer.



3 The role of national organisations in enabling change at the local level

Laura Wilkes and Dan Northam Jones

Laura Wilkes leads the Healthy New Towns programme at NHS England.

Dan Northam Jones was involved in the programme while working in the Strategy Team at NHS England. He now works for Cambridge University Hospitals NHS Foundation Trust.

The Healthy New Towns programme took NHS England outside its natural remit. In recognition that health care services play an important but relatively small part in determining our overall health, the Forward View identified a range of new partnerships that the NHS could contribute to as partial solutions to these wider determinants of health: with research and industry innovators through the Test Beds programme; with the Department for Work and Pensions, local government and employers to support people living with long-term conditions into work; within NHS organisations to improve the health of 1.4 million NHS staff through health-improving employment practices; and through the Healthy New Towns programme, engaging experts in the built environment and community development to deliver new housing developments that help people to stay healthy and flourish in their lives.

This concept of the NHS as an ‘anchor institution’ is reinforced in the long-term plan which commits the NHS to continuing to play a role in ‘shaping the future of the built environment’ through the publication of *Putting health into place* and developing a Healthy New Towns standard for new developments. *Putting health into place* shares the learning from the programme through ten core principles for healthy placemaking which set out how to plan, design and provide healthier and connected communities with integrated and high-quality services.



This learning has been developed through engaging with NHS commissioners and providers, public health and social care departments in local authorities and the voluntary sector and extending our reach into the built environment sector: the developers, builders, planners and advisors who work together to deliver new homes and places; and the people who continue to live in places for generations to come. Some elements of our approach to the programme varied from how other transformation programmes traditionally operate, but we ended up learning many of the same lessons.

While informed by evidence of what works in theory to improve health through housing and the built environment, the programme had the opportunity to learn and disseminate the practical realities of delivering healthier places. An open application process to join the programme elicited far greater interest than we had anticipated – with more than 100 applications – which confirmed that we were seeking to catalyse a rich seam of vision and enthusiasm that already existed in partnerships spanning the length and breadth of England.

Once selected through a rigorous peer- and expert-led review panel, we sought to give the 10 demonstrator sites autonomy from the outset. With limited resources and no new formal levers, change was never going to be driven effectively from NHS England's offices. So we invested heavily in building relationships with key people in each demonstrator site to understand the context and objectives of each partner. This initiated a culture of equal partnership between all parties involved at each demonstrator site, with our account managers working as part of the team rather than marking everyone else's homework. This commitment to listening and learning also helped us to tailor the design of the rest of the programme to enhance and accelerate work already under way in demonstrator sites, rather than duplicating this work or missing potential new opportunities.

We supported key people from across demonstrator sites to form 'collaboratives' for each programme theme, where people doing similar jobs in different sites could network, share learning and solve problems collectively. Over time, these groups became authoritative voices in the programme, setting the agenda for conversations with the national team and leading external engagement on behalf of the national programme. These professionals – collaborating together and drawing common themes from across their work in different demonstrator sites – were the most authentic, knowledgeable and effective advocates for the programme.



As a result, most of our work to raise awareness of the programme and disseminate learning has been done in partnership with the demonstrator sites.

We had far greater ambitions for the programme than simply to deliver healthy places in 10 demonstrator sites. We used well-established links with national bodies in the health and care sector, and also made substantial efforts to reach into the built environment sector.

The basis for building any relationship is empathy – understanding how the work looks and feels from another person’s perspective. We undertook extensive research on the concerns and constraints facing planners and developers, seconded staff to enhance our in-house expertise, and sought multiple opportunities to listen and learn from planners and developers in the demonstrator sites and through national representative bodies. Our relatively recent entry into the sector helped us to be humble and curious about our areas of ignorance while being confident in our areas of established expertise. At best, this created a culture of what Don Berwick at the Institute for Healthcare Improvement calls ‘all teach, all learn’; and the practical reality of working across traditional boundaries made this a daily reality for everyone involved in the programme.

Reflecting on the programme, there are a number of lessons, as follows.

- **New town developments can cut through inertia, but prioritisation is needed because people are busy.** At best, housing growth provides a welcome impetus to cut through the inertia that can stifle change in a large organisation like the NHS. But the complexity and volume of work required to deliver housing schemes requires huge effort, and so partnerships seeking to raise ambitions need to prioritise. It is better to deliver 5 priorities than not deliver 30, and to build momentum through small gains on the way to greater changes that take longer to emerge.
- **Delivery at pace requires dedicated time from an entrepreneurial project manager.** Demonstrator sites recruited people from a wide range of backgrounds as project managers, mostly experienced local government officers and NHS managers. Without this dedicated capacity to develop and facilitate an effective multi-agency partnership, the good ideas of individual people within the partnership will lack the impetus to be delivered in practice.



- **Partnership working is most effective when people understand their distinctive role and value the contribution of others.** Most demonstrator sites built partnerships spanning more than 10 organisations, most of whom had never worked together before. While complex, this environment can create space for each partner to identify what they, uniquely, can bring to the table; it can also clarify how working with others can deliver outcomes greater than the sum of their parts. This requires: being open to learning from others; an acceptance of their terminology, assumptions and objectives; and an ability to find personal fulfilment from getting to know people from these different sectors.
- **Visible leadership is needed at all levels to build and sustain momentum.** Enthusiastic support from senior political, executive and clinical leaders helped to inspire local partners and raise aspirations. The national programme also sought to identify and build supportive voices in professional associations, membership bodies and industry players; it also had strong personal sponsorship from NHS England's former Chair, Sir Malcolm Grant. A steady stream of support – particularly where tied to specific improvements that have been delivered – is highly motivating to the people involved.
- **There is a need to acknowledge and serve the different planning horizons of partners.** The NHS typically plans on a short-term, annual or biannual basis; whereas housing developments typically take several years' work before the first builders move on site. At best, large-scale new housing development presents opportunities to reshape the core business of all public sector agencies working in a place; but, as with many innovative initiatives, they can also attract a narrow escapism from immediate challenges faced elsewhere. Addressing pressing problems in the present helps to build confidence that transformation will meet wider goals in the future. Demonstrator sites that showed progress against immediate imperatives – such as improving primary care access or reducing pressure on hospital services – tended to generate the sustained support from senior leaders that achieving longer-term goals requires.
- **Strive to communicate visionary ideas and make them real, with practical examples and data.** Demonstrator sites have developed a range of communication tools to share success and build awareness of work already under way. Videos have been particularly effective, and work well when used alongside events or projects that engage residents, putting human interaction



with people and places at the heart of the message. Our national approach to evaluation has also brought together stories and statistics to engage people's hearts and minds.

In sum, the three years of the programme brought immense learning on the process of delivering healthy places in practice, as well as further evidence of the benefits of doing this for improving population health. Our hope is that by sharing this evidence and the lessons learned in *Putting health into place*, areas across the country will be able to improve existing places and develop new ones with the health and wellbeing of local people put front and centre, with benefits for generations to come.



4 How local authority planning teams can help create healthy places

Julia Thrift

Julia Thrift is a Projects Director at the Town and Country Planning Association, which was a support partner to the Healthy New Towns programme and was involved in producing the guidance document Putting health into place.

The origins of town planning are closely aligned with those of public health: both disciplines sprang out of an understanding that the conditions in which people live have a profound impact on their health. Access to fresh air, good homes, good food, green spaces, employment and a strong community are the foundations of public health and can be created by, or supported by, good town planning.

In the late 19th century, before there was a planning system in England, Ebenezer Howard created the garden city model of development as a way of planning, funding and building healthy places – and in doing so inspired place-making around the world. Howard also set up the Garden Cities Association, later renamed the Town and Country Planning Association. The Association still promotes the garden city model of development as a practical model for achieving healthier new communities.

Creating places that support population health has, therefore, always been an explicit element of good planning. So what can planners learn from the Healthy New Towns programme?

The first lesson is that today's health problems are radically different from those of the past. Addressing them requires a different approach from councils, from developers, from communities, and from health care providers – and close collaboration between them all. Put simply, the acute illnesses that people tended



to suffer from in the past, such as infectious disease, could often be cured by a course of medicine or a short stay in hospital. Today, a more typical patient might be an elderly widower, living alone, eating takeaways because he doesn't know how to cook, suffering from diabetes and social isolation, and becoming increasingly unfit and overweight. None of this can be 'cured' by a short course of pills. However, social prescribing – such as encouraging him to join a cookery club for older men – could gradually improve his diet, get him out of his home and so increase his level of physical activity, and reduce his loneliness.

For planners, this means that the simple formulae that have been used until now to calculate the health care provision for a new place – for instance, the number of GPs required per 100,000 people – are no longer adequate. Instead, planners, developers, communities and health care providers must collaborate at the earliest stages of planning a new place to ensure that it is designed to make living a healthy life as easy as possible for all residents. When people do become ill, there should be local centres that include community groups and facilities, which provide a range of support and advice, working alongside and collaborating with traditional health care providers such as GPs. Making this happen in practice is not easy.

The second lesson is the importance of focusing on the needs of people who have the poorest health outcomes in order to reduce health inequalities. For planners, this means working with colleagues in public health to understand specific local health priorities. This evidence should be used to inform the council's Local Plan, the framework that guides all development in the area. The Local Plan, supported by public health evidence, can then inform individual planning decisions in a way that could help reduce health inequalities.

Focusing on reducing health inequalities will often require planners to think differently. For instance, planners are used to including cycle paths and footpaths in new developments to facilitate active travel. But if the only people who cycle and walk are those who are already physically active, then this does nothing to reduce health inequalities. Making very fit people that little bit fitter is not the point; however, getting someone who never leaves their home to go for a gentle stroll every day could be hugely beneficial to that person's physical and mental health, as the government has recognised in its strategy, *Everybody active, every day* (Public Health England 2014).



In terms of the built environment, the sorts of things that might encourage less active people to walk a bit more include: installing benches alongside paths so people can rest; signposting pedestrian routes and including the time it takes to walk to the destination, not just how far away it is; and ensuring that there are enough public toilets to give people confidence to leave their homes.

Another new challenge for all of us is to understand and try to improve the 'food environment'. Put simply, when people move into the new place, will fresh, healthier food be easily available, affordable and a normal part of everyday life?

To address this, the Healthy New Towns programme suggests that when creating a new place, planners should ensure that there are well-connected public spaces that could be used for street markets; that allotments and community gardens are provided close to new homes; that streets are planted with fruit trees; and that new school buildings are designed with attractive, spacious dining areas. It is also vital to ensure that kitchens in new homes are large enough for people to store and prepare fresh food, and to have a freezer. It might seem extraordinary that a new kitchen would not be large enough for such essentials, but the homes built in England are some of the smallest in Europe and, apart from in London, there are no statutory minimum space standards to ensure that rooms are large enough for the intended number of occupants or uses.

The lack of mandatory housing space standards is just one of the challenges that planners face in practice when trying to create healthier places. Although the Healthy New Towns programme provides useful new learning for planners about 21st-century health needs and health care, much of what it recommends is (and has been since the days of Ebenezer Howard) the essence of good planning. Poor-quality developments are being built in England, but not because planners and architects don't know how to do better: in general, they do.

So why isn't it happening? The reasons are complex. They include weak policy and 'optional' built environment standards, wavering political will, and – at heart – a deep-rooted ambivalence about the role of the state in shaping the places in which we live. The planning system is, too often, perceived to be a block on new development, rather than a democratic (and therefore imperfect) process of mediating between different demands to create places in which people can



thrive. In 2018, the Town and Country Planning Association published the final report of the Raynsford review ([Town and Country Planning Association 2018b](#)). This 18-month inquiry into the English planning system concluded that it is no longer fit for purpose and needs rethinking from first principles if it is to shape good places. In the context of such a dysfunctional planning system, high ambitions to plan healthier places will be undermined by multiple practical difficulties.

The biggest difficulty is this: how can good-quality new places be created in poorer parts of the country, where land values are low and where people are worse off – and less healthy? If the Healthy New Towns programme only results in better places for better-off people who already have better health, it will have failed.

It is difficult not to conclude that if England is serious about planning healthier places, then the state must play a stronger role. There must be a new set of built environment quality standards, informed by public health evidence, which are mandatory not optional (as is currently the case with standards in current national planning policy). In areas of low land value, where the private sector is unable or unwilling to develop good-quality places, then the state will have to contribute, perhaps by taking a direct role in the development process.

The places we build today will be lived in for at least 100 years. If the state does not invest in ensuring that they are good-quality places that support communities to live healthy lives, then much of the cost of getting it wrong will be paid for, eventually, by the state itself through ever-increasing demands on the NHS.



5 Taking a community development approach to health

Amanda Hill-Dixon

Amanda Hill-Dixon is a Senior Researcher at The Young Foundation, which was a support partner to the Healthy New Towns programme and was involved in producing the lessons learned document Putting health into place.

When thinking about how to create healthy new places, community development is unlikely to be the first answer which springs to mind. Ensuring the provision of high-quality health and social care services, and planning and building a health-promoting built environment, are probably more likely to feature.

However, based on the experience of the 10 Healthy New Towns programme demonstrator sites, and very much in line with The Young Foundation's own experience, strong and sustainable communities are a key ingredient for creating a healthy, successful and thriving new place. This is the subject of the third of the 10 Healthy New Towns principles described in *Putting health into place*, 'Connect, involve and empower people and communities'. The evidence for social connections as a driver of health and wellbeing is increasingly compelling: loneliness increases the likelihood of death by 26 per cent, and people with strong relationships are 50 per cent more likely to survive life-threatening illnesses. Strong communities can help people form these relationships, can provide opportunities for social and civic participation, and can help to foster feelings of belonging and inclusion.

Based on this recognition, the Healthy New Towns demonstrator sites have been investing in the creation of new places that are socially as well as environmentally and economically sustainable. The creation of new places offers a unique opportunity to take a fully systemic approach to creating healthy places in which



the physical environment, local services and the social environment can all be crafted and designed from the outset in ways that enable health and wellbeing. This contrasts with efforts in existing places which so often face a whole range of legacy constraints. However, the ‘blank slate’ of a new development also presents challenges from a community development perspective – how can you engage or work with a community that doesn’t yet exist?!

The Healthy New Towns demonstrator sites have shown that there is almost always an existing community that must be considered, engaged and included in development work from the outset. This is important if we want to avoid creating and aggravating inequalities between existing and new neighbourhoods and residents. For example, the Edible Ebbsfleet initiative, which turns unused public spaces into community food-growing gardens, has been adopted across existing and new neighbourhoods, helping to stitch together these diverse communities. Teams in Darlington and Ebbsfleet have also been working with existing residents long before houses started being built – for example, through activities, events and the creation of street furniture that celebrates the history and heritage of these existing places. This emphasises that changes do not have to mean the erasure of local history and culture.

As well as helping to lay the foundations for cohesion and shared benefits across existing and new neighbourhoods, existing neighbourhoods also hold many of the assets and strengths that can serve as the foundations for effective community development and health creation across old and new communities alike. This has parallels with the health sector. Taking a strength-based or partnership approach to working with patients, drawing on their knowledge, experience and preferences, is increasingly valued in the health sector as a more ethical and effective way of working with individual patients. It is also reflected in the NHS long-term plan’s commitment to giving people more control over their own health and more personalised care.

The work of the demonstrator sites, and community development practice more widely, show us that this strength-based approach is also necessary when seeking to bring about health improvement at a community or population level. Planners, developers and health care agencies can take a strength-based approach to working with whole communities – recognising and supporting (for example, through social prescribing) local assets and opportunities, such as neighbourhood networks,



voluntary sector organisations, and grass-roots community initiatives. This contrasts with many dominant behaviour change models, which focus on the needs and deficits of individual people or communities, such as poor ‘lifestyle choices’ or an ‘apathetic local culture’. Instead, preventable health problems are seen and treated as shared challenges with shared solutions.

The Healthy New Towns programme has also shown that a strength-based approach to working with people and communities is also fundamental to building meaningful neighbourhoods-level relationships. As well as forming the fabric of a community, relationships can spur and enable people to take action to address shared health challenges and priorities. For instance, in Thames Ward, Barking, a group of young men, supported by the development corporation Barking Riverside Ltd, have come together through a radio project to start a podcast club about young men’s mental health. In Darlington, residents have come together to form the Friends of Red Hall group to co-ordinate community opportunities, such as a community library, and to develop shared decisions for the area. As well as directly addressing the social determinants of health, such as education, these projects help to strengthen local relationships (themselves a key driver of health and wellbeing) and to foster a sense of agency and attachment to a given place.

Many of the insights gleaned through Healthy New Towns, shared in *Putting health into place*, are very much applicable to existing places. There remains scope for applying a community development approach to health and wellbeing in these contexts too. For example, in Tower Hamlets – one of the most deprived local authorities in the country – rather than focusing on local deficits and needs, the Council Health and Wellbeing Strategy builds on residents’ strengths, interests and priorities in order to boost health. This includes the Communities Driving Change programme, which is being led by The Young Foundation in Bethnal Green, in partnership with Real and FutureGov. The programme is driven by the local community, and has three key mechanisms:

- developing an understanding of shared priorities for health and wellbeing – for example, through participatory research and consensus-building
- relationship-building, between residents and with local institutions – for example, through community events that are co-designed and co-delivered by residents and local institutions



- supporting local residents – for example, through training and mentoring, to generate and implement their own ideas for change. These have included peer-led English language courses, coffee mornings, and intergenerational exercise classes.

One of the most powerful effects of this work is that it necessarily changes the relationship between residents and institutions; they start working together on the basis of partnership, rather than on the basis of being consumers of services or local resources.

Community action isn't and shouldn't be the only or main way to improve health and wellbeing in new developments. Strong and well-resourced public services, and well-designed and maintained public spaces, are absolutely essential. Without them, communities are eroded. In turn, without strong and active communities, people – and the services that exist to support them – are weakened. Healthy New Towns has shown us that by investing in both, and by encouraging communities and institutions to work together and support each other, we are all better off. But this does require fundamental changes in the relationship between residents and institutions during the development process, including a willingness to share power and acknowledge that expertise comes in many different forms and from many different quarters.



6 Bicester as a living lab

Rosie Rowe

Rosie Rowe is the Programme Director for the Bicester demonstrator site and works in the Wellbeing Directorate of Cherwell District Council.

‘Connector’, ‘catalyst’, ‘driver for change’ – all these words or phrases have been used to describe the Healthy New Towns programme at Bicester and its approach to promoting a radical shift to health creation. The radical nature of the programme lies in its place-based, system-wide approach, recognising that different parts of a system – from businesses to schools to GP practices to community leaders – need to collaborate to impact on the wider determinants of health. The programme inverted the traditional narrative about needs, gaps and services – looking instead to understand what assets and strengths a place has, how organisations can work together to build on them and create a stronger, health-enabling environment and community. At the heart of the healthy place-making that we have been testing in Bicester (and in the other nine demonstrator sites) is partnership working and testing the impact of what happens when partners come together to develop a healthy community.

My first involvement with healthy place-making in Bicester came in August 2015 when I represented Oxfordshire Clinical Commissioning Group (CCG) at a meeting of interested organisations drawn together by Cherwell District Council to develop a proposal for Bicester to become one of NHS England’s demonstrator sites. At this initial meeting, the level of enthusiasm to work together as partners was both infectious and inspiring, and this willingness to work differently together has been sustained throughout the programme.

Our level of ambition for Bicester has always been high – we agreed that we should aim for the Bicester Healthy New Towns programme to radically rethink the approach to health and wellbeing, enabling people who live or work in Bicester to live healthier lives in order to prevent illness in the future. We were equally



clear as a partnership that, despite its name, the programme needed to seek to improve the physical and mental health of everyone in Bicester – the existing community as well as those moving to the town. We saw it as an opportunity to show existing residents that housing growth could bring benefits, including increased investment in the town, and we have sought to use the programme as a mechanism to increase social cohesion. All credit to the national programme for allowing this flexibility; we think this mature approach of boundary-setting centrally but allowing health and wellbeing priorities – and the mechanisms to address them – to be determined locally is one of the reasons why the programme has been so successful.

Partners around the table could also see that the Healthy New Towns programme was a great opportunity to test out new ways of working, using the opportunities presented by population growth to test innovations in the built environment, new models of care, and community activation to improve health and wellbeing. We have used it as a catalyst to bring different local stakeholders together – not just public services such as health and local government, but schools, local businesses, GP practices, and local community groups who share a common interest in improving the health of residents in their town. We realised early on that if *Healthy Bicester* is to become a reality, then it needed not just the endorsement of our partners, but they really needed to have a sense of ownership so that it was their programme, not just a short-term NHS England project. This meant that we needed to co-design and co-deliver the programme together as a partnership, recognising that the insight and capacity of our local partners needed to steer both the activities we decided to undertake and how they were delivered. To give an example, a Family Fun programme was delivered to encourage families to get active together. Bicester is fortunate in having very low unemployment but, in many families, both parents work – sometimes different shifts. One of the primary school headteachers explained that as a result, ‘family time’ during the week is often limited to between 6pm and 7pm, so we designed the programme to run in this time slot. Thanks to being a demonstrator site, we were allowed to take the time that such co-production requires to develop a programme that local organisations and residents would support.

National funding for such an ambitious programme has been relatively limited but the programme has addressed this challenge by using its ‘demonstrator status’ as a mechanism to secure additional investment from sources also open to other



areas. For example, additional GP time has been allocated to deliver innovations in the management of care for people with long-term conditions by making Bicester a test bed for a new diabetes care pathway for the rest of the county. Building on the enthusiasm and support of partners has enabled the programme to secure additional grant funding and to leverage resources in kind, making sure that public funding delivers real value for money.

Early on, partners recognised that a key priority was to develop a new approach to planning so that future health estates could deliver new care models and meet the needs of the expanded population of Bicester. The Healthy New Towns programme provided the impetus for creating a culture shift in working together. Bringing together GPs, planners and health commissioners on a regular basis has resulted in stronger working relationships and a better understanding of each other's operational constraints. This has provided the platform upon which to collectively review Bicester's health estate and plan for new facilities. Although this is not a quick fix, this mutual understanding of each other's needs and constraints is essential to secure appropriate sites and developer contributions that will fund provision of health facilities.

Our partnership has also included expert support from public health and academic partners at Oxford Brookes University, Oxford University and, more recently, Newcastle University. One of the emerging findings from their evaluation is how the programme has acted as a system connector to 'bring everyone around the table', to share knowledge and collectively innovate to find ways to improve outcomes for all. Bringing a broad range of partners together to develop a shared vision is a key message in the first of the 10 Healthy New Town principles, 'Plan ahead collectively'. It is when organisations interact together to deliver a shared vision that positive systems change is able to emerge, which in turn will support individual behaviour change and improvements in health and wellbeing.

There have also been indirect consequences that we could not have predicted at the start of the programme but which in turn have supported community cohesion. So when we installed 5km health routes in the town to nudge residents into being more active, we were delighted to learn from social media that residents were using them to explore areas of the town they did not know, for fathers and teenage daughters to chat as they walked, and for strangers to say hello and enjoy a sense of solidarity as they 'walk the blue line'.



Systems change takes time and some dedicated resource, especially if it requires many actors in the system to work differently. The conversation becomes different, from 'I've got this intervention. I need to make it work in this context...' to understanding the place as part of an interconnected whole and how to create the conditions for systems change. Local partners have welcomed the opportunity to step out of their silos and discover ways that they can work together to improve the support offered collectively to residents. As a result, the key priority is building and sustaining relationships, recognising that a healthy system is dependent on strong relationships between the actors in that place.

As someone with a health background now working in local government, I now appreciate the powerful assets that my colleagues have in terms of their relationships with local communities, not just with key stakeholders but in terms of their connections with residents. The insight that this generates is a powerful driver for effective place-based working; if primary care networks want to promote prevention and deliver a population-based approach to delivering care, they would do well to ensure that their local government partners are involved in decision-making from the outset. It's certainly something that I will be seeking to establish locally as we sustain healthy place-making in Bicester and other parts of Oxfordshire.



7 The role of public health teams in creating healthy places

Virginia Pearson

Virginia Pearson is Chief Officer for Communities, Public Health, Environment and Prosperity at Devon County Council, and has played a leading role in the demonstrator site at Cranbrook.

Public health is all about places – and the people in those places. We build understanding of people’s lives by means of routine data, bespoke data and insights into how people live. We aggregate these datasets into the intelligence that forms the statutory Joint Strategic Needs Assessment, making recommendations about how to improve health and wellbeing and reduce health inequality. This becomes the starting point for our wellbeing, health and care planning with partners – unless there is no population!

This is the kind of challenge that a new town or development poses for public health teams – local authority-based, working in partnership with colleagues in Public Health England. The public health connection with our brand new town in East Devon – Cranbrook – began in 2005 when one of our public health registrars worked with strategic planners at the county council to consider how a new town might, in itself, improve health and wellbeing, through a health impact assessment (*Cave et al 2007*). That concept of building health and wellbeing into planning was important as it has influenced our approach since, and has been energised by the awarding of Healthy New Town status for Cranbrook in 2016. I took over the role of chair of the Cranbrook Healthy Town Executive Group in 2017 when we put in place new governance arrangements.

The overall design for Cranbrook put the community, access to green space and sustainable public transport at its heart, with an early commitment to ensure that



the primary school – central to the new community – was ready for the families who were moving into their new homes. And this happened very quickly, so the emergence of the new community rapidly outstripped any knowledge we had from routine data on local population needs. Changes to data from the Office for National Statistics (ONS) meant that we were no longer able to use postcode-level data and the lower layer super output areas did not fit the boundaries of the new town, crossing not just geographical but also organisational boundaries. The other main factor was simply the speed of increase in the size of the population – new occupants were moving in quickly and we had little information about demographics or population need.

That has been the first learning point – how to build intelligence about the future needs of the new community. In the early stages of the town’s growth, insights from community leaders or ‘anchors’ (for example, a school headteacher or a local minister) became an important source of understanding, supplemented by what routine data we had available, to inform a Cranbrook needs assessment. These individuals were able to share knowledge about the characteristics of the emerging population that were not visible from the data at that stage. Research about the demographics and health needs of similar new towns produced a population projection, which we took the lead in sharing with partners to consider how the wider system – health, care, police, education, planning – would need to respond to the rapidly growing town. This early approach, based on what community engagement and community leaders were saying about the emerging town, enabled us to bring together a range of partners, who have continued to work together through the programme.

We have also been able to bring the best of public health intelligence together with spatial planning to better understand predictors of future health and wellbeing in the population of Cranbrook and to understand how the built environment impacts on physical and leisure activities. Without the support of the programme, we would not have been able to build these valuable insights that have influenced the Cranbrook Masterplan.

The second learning point has therefore been that while formal considerations of population-based health and wellbeing, and health and care services, still need to be better embedded in national planning requirements, building a better understanding between partners has been very beneficial. With further large



housing developments planned in Devon, these relationships will stand us in good stead.

The Healthy New Towns programme has shown how a new way of thinking can contribute to our future plans. As a county council-based public health team, we have worked alongside the town and district council, the CCG, the local NHS hospital trust, social care, police and other partners to develop models of delivery that will meet future need. Our county sports partnership, Active Devon, has taken a lead role in the promotion of physical activity, using the availability of green space and cycleways with a young family population to develop community-led initiatives such as the award-winning Active Mums programme. The Exeter and Cranbrook area has recently been chosen as one of the Sport England Local Delivery Pilots, which provides the opportunity to use learning from the Healthy New Towns programme to increase levels of physical activity, especially in less physically active people. Backed up by high-profile events such as the start of the 2018 Tour of Britain stage in Devon, and theme-based community events, Cranbrook is visibly engaged in health-promoting activities.

That is not to say, however, that only physical health is a priority: Cranbrook schools have been working with the public health nursing team and our Early Help for Mental Health service to promote emotional wellbeing, mental health and resilience, complemented by locally tailored approaches, with support from the Healthy New Towns programme, such as the Family Vision programme (Berry *et al* 2019). Working with influential local clinicians (such as our GP locality chair), the local GP practice and community pharmacist, new models of care are being developed for a population with a very different demographic profile from the rest of Devon.

As a Director of Public Health, the opportunity to contribute significantly to the programme is twofold. It is not just the traditional skill set that public health brings as technical experts, primarily understanding and interpreting population health and care needs, using evidence to plan health-promoting places for people, seeking to improve health and wellbeing and reduce health inequalities; it is also stepping into the leadership space as a systems leader – recognising that ‘place’ is a complex adaptive system, and that building relationships, influencing and advocating for health are therefore just as important skills to have.



8 Shaping the next generation of new towns and garden cities

Kevin McGeough

Kevin McGeough is the Head of Place-making at Ebbsfleet Development Corporation and Director of the Ebbsfleet Garden City Healthy New Towns programme.

Being Director of the Ebbsfleet Garden City Healthy New Towns programme has been an exciting and incredibly fulfilling opportunity, where I have been able to bring together my personal passion and professional knowledge of place-making to the design and delivery of the first Garden City in the United Kingdom for 100 years, the first New Town for 50 years, and the largest of the Healthy New Town pilot sites.

Having grown up in Craigavon New Town in Northern Ireland, and later working on a portfolio of former New Towns through various roles with English Partnerships and Homes England, I am a self-confessed 'New Town nerd'. I have also been very interested in learning from the United Kingdom's legacy of planned communities such as New Lanark, Edinburgh New Town and Saltaire – all of which are now UNESCO World Heritage sites – because of their international value in demonstrating the importance of balancing moral, social, health, environmental and economic objectives in place-making to improve the quality of life of the people who live and work there. To use an example from the 19th century, moving 8 miles from Bradford to Saltaire in 1856 increased average healthy life expectancy by 50 per cent, through the provision of sanitary housing and good working conditions.

However, as a child of the British New Town concept, I am acutely aware of what can go wrong. So, while Milton Keynes has been proclaimed by the Centre for Cities as one of the most successful growth locations economically for the past



three decades, many of its contemporaries tell a very different story. Craigavon had 25 per cent of its housing demolished and became part of the European Commission's 'Poverty 3' programme within 20 years of inception, due to the social exclusion and related poor health indices evident among its residents. In 2018, a HOMES (Healthier Outcomes Making Homes Safer) report published by Breaking Barriers Innovations and West Lancashire CCG highlighted that tackling the impacts of poor New Town housing today in Skelmersdale was their number one health priority (Patel and Bashford 2018).

Ebbsfleet's challenge therefore was to build on the lessons from the best and avoid the pitfalls of the worst examples of planned new communities in the United Kingdom. As a Healthy New Town, we have had an opportunity to put 'health' in its widest context at the heart of the vision and values of the Garden City. This commitment was manifested through the focus on health as a key delivery theme in the Corporate Plan and Implementation framework published by Ebbsfleet Development Corporation (EDC) in spring 2016. The EDC was set up by government to speed up the delivery and improve the quality of up to 15,000 new homes and up to 30,000 new jobs in a proposed new Garden City focused around the existing Ebbsfleet International station. The Corporation has been entrusted to ensure that delivery of the North Kent site reflects the community-spirited ethos and sustainable principles of the Victorian and Edwardian Garden Cities, reinterpreted for the 21st century and applied to its post-industrial location. The EDC was given up to £275 million in its first five years to invest in supporting infrastructure delivery, and it has assumed planning management powers to help streamline the delivery processes.

The Healthy New Towns partnership at Ebbsfleet includes Dartford Gravesham and Swanley CCG and Kent County Council. This partnership has allowed us to collectively step back and rethink our individual roles, and to work together to do things more creatively, innovatively and effectively. Our steering group, which cut across the health, public health, adult social care, sports, education and built environment sectors, included representation at a high level, allowing us to shape policy and delivery not just in Ebbsfleet but across the county and further afield. Collectively we have been able to explore new projects and programmes, ranging from an ambitious £500 million proposal for a Health, Education and Innovation Quarter at the heart of the new city centre, to a Fitbit physical monitoring



programme with new and existing residents. One good example of our collective approach has been in defining the primary care vision for the new city. We used a series of collaborative design workshops to bring together more than 250 people, including residents, GPs and wider health professionals to design the brief for our proposed health centre. The result is a proposal for a flexible community facility that is less focused on medical care and more focused on wellbeing.

The most significant impact of the programme in Ebbsfleet has been realised through our community-building role. Often, considerations as to what it will be like to live in a New Town are overlooked in a race to deliver new infrastructure and housing. However, as the joint national lead in the Healthy New Towns community collaborative, we have been enabled, in partnership with NHS England, to help new and existing communities to test a range of tools to help themselves to Get Active in Ebbsfleet. Through local food-growing, healthy eating, arts, culture and physical activities, we have been able to help residents adopt a lifestyle that makes them happier, healthier and connected with their community, making them less likely to suffer from medical conditions and to ensure that living in the Garden City can be fun and engaging from the outset.

Healthy New Towns are a strong and powerful brand. Interest in our projects, programmes and initiatives at Ebbsfleet Garden City has been phenomenal, attracting local, national, and international media attention. Our Edible Ebbsfleet project, which involves growing free food in local schools and public spaces, was featured by ITV News; our Better Points application to reward physical activity was the focus of Radio 4's *World at One* programme; while our winning entry for the Landscape Design Challenge, illustrating how to design-in healthier behaviours, attracted more than 500 million social media views. In turn, our developer partners have seen the value and potential in the NHS England Healthy New Towns brand; for example, local developers such as Clarion and Redrow have joined 10 other home builders to form the NHS England Healthy New Towns Developers Network, each committing to developing and sharing best practice in housebuilding and place-making for the future.

Working with the other nine Healthy New Town demonstrator sites has been inspiring, and I will be picking up lessons from each site to apply to practice and delivery in the future at Ebbsfleet. Each site had different partnerships and was led



by individuals with different skills and passions. Collectively, we were able to test more new ideas than if we had had to follow a defined programme. For example, my personal background in architecture and urban design complemented the public health expertise of other demonstrator site leads, allowing us to learn more from each other and achieve more across the programme.

The continued support and commitment of NHS England has been invaluable. Through continued commitments to the Healthy New Towns programme and a pledge to develop a quality mark for new housing in the long-term plan, NHS England has positioned itself as central to the national place-making agenda and re-established the important policy links between health, housing and care. This commitment is encouraging other government departments, such as the Ministry of Housing, to work collaboratively once again as they did when the NHS was set up 70 years ago.

On reflection, it would have been more effective if the funding provided to demonstrator sites had been structured in a way that made it easier to plan longer term. If we had had a clear idea from the outset as to what support and funding would be available over the three-year period, we would have been able to take a more ambitious approach and invest in projects with a longer time horizon. In a programme of this kind, the ideal would be to be thinking from the start about sustainability and investing in projects that would have an impact over 5–10 years, beyond the lifespan of the programme itself.

Notwithstanding the lessons on planning and budgets, I do feel the programme has been a success. It has been greatly valued by the new and existing residents at Ebbsfleet and helped start new conversations and ways of thinking that will shape 25 more years of delivery in the Garden City. Healthy place-making will remain at the heart of Ebbsfleet Garden City moving forward, as it makes good common sense. The team that was set up to deliver the programme will continue as an integral part of the EDC, while the steering group will support the delivery of the key projects identified, including our health and wellbeing hub, seven new city parks, and a new model for intergenerational housing.

Our experiences at Ebbsfleet are being widely shared and can help shape a further generation of new towns and garden cities. Ebbsfleet Garden City is the first and largest of these designations, with a further 29 having been announced by



government. We have hosted visits from many of these future communities who have been excited by our initiatives, and we are encouraged that many of them are already bringing together similar cross-sector partnerships with health at their heart, drawing on the insights contained in the 10 Healthy New Towns principles. As such, I feel it has not been so much a programme as a revolution, where the understanding of how people will live in new places is now understood as being just as important as the delivery of the physical places themselves.



9 Effective partnership working for healthier neighbourhoods

Louise Upton and Joe McManners

Dr Louise Upton and Dr Joe McManners are elected members of Oxford City Council and have been closely involved in the Barton Park demonstrator site.

Over the past three years since 2016, we've witnessed the transformative potential of bringing together local authorities, primary care providers, developers, and community and voluntary groups to improve the health of residents in a deprived, urban neighbourhood.

We are both Oxford city councillors but we also happen to have roles in the health sector (one of us being a practising clinician). So when NHS England announced the Healthy New Towns programme in 2015, we both supported a bid for funding to leverage resources for Barton, which is a neighbourhood of Oxford that has higher levels of health inequality compared to other more affluent parts of the city (for example, average life expectancy for men is 12.6 years lower than in North Oxford).

The bid that went in was a fairly conceptual proposal. Its purpose was to make sure that housing development at Barton Park (885+ homes) created opportunities for promoting healthier living among residents, with a focus on improving the built environment, encouraging community activation and exploring new models of care. We were particularly minded that any such activity must work across both the new and existing housing estates to encourage social integration. However, it wasn't until we were awarded funding the following year, and after extensive conversations with colleagues at Oxfordshire County Council, Oxfordshire CCG and Grosvenor (the developer of Barton Park), that a more concrete idea of what could be done emerged.



In retrospect, there were two very important decisions that were made during the first year of the programme. The first was the decision by the city council to use Section 106 funding (financial contributions from the developer agreed as part of the process of gaining planning permission) to increase the physical size and capacity of the doctor's surgery (Hedena Health) in the existing neighbourhood centre rather than creating a new facility in the newbuild area, Barton Park. The second was the decision to offer small grants totalling £30,000 to existing community and voluntary groups to come up with and deliver activities that encouraged physical exercise and promoted healthier eating in the neighbourhood. As such, we saw the provision of breakfast and lunch clubs, cooking courses, improvements to the existing open-access food bank, classes promoting exercise, and a scheme helping residents overcome isolation and attend GP appointments – most of which happened in the neighbourhood centre. This was the beginning of a 'health hub' in Barton.

The emergent idea of a health hub was simple: we wanted to create a space in the existing neighbourhood where there were co-located clinical services and community activities that promoted health and wellbeing, which both new and existing residents could use.

Building on this concept, in the second year, further work was undertaken with Hedena Health and Manor Surgery (also serving Barton) to identify, better understand and create new community-based support opportunities for residents with long-term health conditions such as cardiovascular disease, liver disease, asthma, diabetes, chronic obstructive pulmonary disease (COPD), drug and alcohol abuse, hypertension and depression. Using funding from the Healthy New Towns programme, GPs – and, critically, a social prescriber based in the neighbourhood centre – were tasked with referring these patients to the activities already running in the community, as well as other clinical interventions funded by Oxfordshire CCG throughout the city.

Over the course of the programme, primary care practitioners reported that there was a small cohort of patients frequently presenting to GPs, calling ambulances and attending accident and emergency (A&E). It was believed that many of the problems these patients presented with were caused by social and economic factors. In response to this, and to meet NHS England's call for 'investible propositions'



for the third year of the Healthy New Towns programme, we devised a new model of care called Team Around the Patient (TAP). This involved identifying the most frequent users of primary care services in Barton and setting up planned multidisciplinary meetings for GPs, nurses, social prescribers, mental health, social care, ambulance service, hospital staff and officers from the city council's housing and community safety teams to discuss these patients' individual needs and plan more appropriate, holistic support for them, linking with all relevant services.

So what has been the impact of this work? An independent evaluation commissioned by the council found that 662 residents used the various community activities funded in the first year of the programme, equivalent to £37 spend per head. In interviews, many of these people said the activities had been good for them, particularly in terms of being able to socialise; but long-term behaviour change is harder to measure. In terms of referrals for people with long-term health problems, we have more data: 322 patients were successfully taken through this process over two and a half years at an estimated cost of £80,000. Again, users and practitioners described physical and social benefits, and analysis suggests that the initiative reduced demand on primary and secondary care services equivalent to £79,000, making it roughly cost-neutral. As for TAP, it's too early to tell whether this is making a long-term difference to the lives of the patients involved, but the activity is already being sustained beyond the life of the programme because of the value that colleagues at these surgeries place on it. Benefits include closer relationships between health services and council officers, data sharing, and better processes for engaging patients and considering their needs through a multidisciplinary lens.

And what have we learnt? Well, as councillors (and clinicians) we have a clear view of the importance of local authorities but also see distance between health providers and local government. We also appreciate that people's lives (and health) are intricately connected to places and the opportunities available to them in their neighbourhood. From our experience and knowledge of what has happened in Barton, we have been really excited to see how programmes like this can break down barriers between agencies and provide practical examples of how things can be done differently at a community level, focusing on residents' wellbeing. By participating in the whole programme, the GP surgeries, health services, city council and community groups have created a powerful and long-lasting partnership based



around a local population. We expect the initiatives that have been started here to continue because there are clear benefits to all to work together, but this does take time and organisation.

As local councillors we feel that in the future, using councillors as a 'bridge' between local communities and health organisations (which can sometimes tend to be inward looking and focused on a 'medical model') will be key to success. Support from councillors will be vital in connecting new models of primary care (particularly 'primary care networks') with local people, and heading towards more of a 'social model' of health. This draws on the often-shared insight of both primary care professionals and councillors that place and community are major factors involved in shaping population health.

In an era of austerity, councils and health providers are having to be more creative in their support for communities. We hope the government can learn from the experience of the Healthy New Towns programme to see how innovation and a culture of partnership working can be fostered at a neighbourhood level and benefit residents at relatively low cost. It is a model that we think can be built on and 'supercharged' in the move towards primary care networks.



10 The opportunity to redesign primary care in new places

Irina Higginson and Clare Gibbons

Irina Higginson is Programme Manager for Northstowe and New Models of Care for Cambridgeshire and Peterborough Sustainability and Transformation Partnership. Clare Gibbons is Programme Lead for Northstowe Healthy New Town at South Cambridgeshire District Council.

The planning for primary care in Northstowe began many years before the first brick was laid. GPs can play a valuable role in helping to design healthy places and we invested time and energy early on to develop collaborative relationships with six GP practices in the footprint of Northstowe. The Healthy New Town programme lead, together with the Assistant Director of Primary Care at Cambridgeshire and Peterborough CCG, met with each of the practices to update them on the housing development, the nature of the population expected and the opportunities it might offer to develop a new model of care.

We held a visioning event and invited local GPs, practice managers and representatives of the patient participation groups. That event produced some clear guiding principles: the model developed should be clinically led, designed to support the agency of the patient and be shaped by the community, requiring outreach beyond the usual suspects.

With partners' interest stimulated by the visioning event and recognising the pressures experienced universally by primary care, GPs from the six practices neighbouring Northstowe organised a series of meetings. They discussed how they might respond to the opportunity Northstowe presented, moving towards



more integrated services to cover both the new community and the surrounding settlements in which their practices were located. This coincided with the drive to identify and establish neighbourhoods of 30,000–50,000 in accordance with the sustainability and transformation plan for Cambridgeshire and Peterborough. GPs were supported to participate in this process by the provision of payments for backfill by the Healthy New Towns programme, freeing up time for GPs to engage and creating clear space to think beyond the day-to-day demands of their practice.

We were able to learn from previous large-scale developments in South Cambridgeshire such as the town of Cambourne. The GP who established the new practice serving Cambourne was able to provide insights into the health needs that presented as this community established itself, along with primary care data analysis. Based on this prior experience, we knew to expect a number of things – for example, that without active intervention the demographics in new communities tend to be skewed towards a much younger population than surrounding areas, with a higher birth rate. We have sought to avoid this in Northstowe by providing a range of housing, including houses designed to meet the needs of older people, so that the new community has balanced demographics that better reflect the surrounding population.

Other lessons learnt from Cambourne included higher demands for mental health care to treat low-level depression and anxiety, thought to arise due to a lack of social networks for residents to access in the early days of the development. As a result, our approach in Northstowe has been to actively cultivate the development of social networks, signposting residents to new and existing networks to help them feel connected to their new community at an earlier stage.

A key part of the proposals for primary care in Northstowe involves the development of an integrated civic hub that contains health services, a library and other community facilities in a purpose-built building costing £14.5 million (principle 10 in *Putting health into place* describes how to go about planning and building an integrated health and wellbeing centre of this kind, and the benefits of doing so). The ambition is to design these premises in such a way that they are flexible and adaptable, easy for patients to navigate, incorporating design features that have carefully considered the needs of specific groups (such as people with dementia), and providing a dedicated space for multidisciplinary team



meetings and a touchdown point for community and social care teams. The aim is to support integrated working and a hub-and-spoke approach linking to clinics in neighbouring villages.

This civic hub will be built as part of phase 2 of the development. The analysis suggested that for the first 4,000 residents, the need for GP services could be met by an expansion of an existing branch surgery in the nearby village of Longstanton, with the needs of residents who move in subsequently being met at the civic hub (a similar analysis was conducted for pharmacy and dentistry services). It is, however, important to note that the rate and scale of growth in the surrounding villages is less easy to account for and introduces additional unknowns when trying to calculate future needs.

The most appropriate way of contracting for new primary care services has required significant thought and discussion. It has been a challenge to offer a viable primary care contract service that meets the needs of residents and of the workforce, as it is unaffordable to provide services before the population moves into the area. We have also had to carefully consider the approach to contracting as Cambridgeshire and Peterborough CCG is unable to enter into a new General Medical Services (GMS) contract, despite this being the preference of local GPs. We are aware that time-limited Alternative Provider Medical Services (APMS) contracting solutions are less attractive to GPs and do not support the continuity of care that the new care model we seek to develop aspires to.

Throughout the process of drawing up plans for Northstowe we have needed to understand that decision-making cannot outpace GPs and other service providers; we need to develop plans and design governance in such a way that enables them to be in the driving seat of care redesign.

We also need to make patients' voices a key element in planning services. In keeping with this, we have embarked on a process, sponsored by the Eastern Academic Health Science Network (EAHSN) and the Healthy New Towns programme, to understand what people want from their health services. This patient participation appraisal process will involve the training of individuals from a wide range of backgrounds across the east of England to lead focus groups drawn from their own



networks to consider what they require from health services and how the delivery of those services could be tailored to meet their needs more effectively.

We believe we are overcoming the barriers to developing a Healthy New Town by collaborating across the system. The sustainability and transformation partnership is now looking to Northstowe as an opportunity to pilot more innovative approaches – for example, through its digital workstream. We would strongly encourage other new housing developments with a primary care element to look at the detail in the NHS long-term plan to deliver a better-informed solution for primary care provision.



11 Using digital technologies in health and care services in new communities

Hilary Hall

Hilary Hall is the Project Manager for the Darlington demonstrator site.

In Darlington, there was a strong feeling that we would be missing a trick not to harness digital technology to help overcome the challenges of managing demand and making care services more user-focused. We also wanted to get better at integrating local authority plans for housing expansion and neighbourhood renewal with health plans for better meeting the needs of local communities. To do this we brought together a coalition of the willing, including some private sector partners who were willing to take the journey with us: a housebuilder, Keepmoat, and a digital infrastructure provider, Inhealthcare.

The drivers for embracing digital technology locally were to:

- manage ever-growing demand by remotely monitoring and triaging patients, reducing visits and streamlining pathways
- use the available funding and staffing more efficiently
- empower and educate patients
- provide greater choice and convenience.

We have piloted a variety of approaches, including the following.

- Using technology to monitor patients remotely – giving greater control to patients, freeing up clinician time, providing better ongoing monitoring and



connection between patient and clinician or reducing the need for outpatient or primary care appointments, and reducing unscheduled care and admissions in the case of care homes. (In the first six months of piloting the care homes module it achieved a 25 per cent reduction in unscheduled community nurse visits to the care home involved and a 31 per cent reduction in admissions.)

- Digitising administrative or support processes (such as flu jab appointments, collecting smoking status).
- Implementing online consultations – achieving one of the best uptake rates in the country and very positive patient feedback.
- Experimenting with apps to support long-term conditions management, providing more accessible information, education and ongoing support and advice.
- Developing a predictive modelling tool to assist primary care to understand the impact on staffing of changing demographics and housing growth in the area.

Some of these initiatives have worked better than others, but one thing is clear: where you can get a product that has clear benefits to clinicians in making better use of their time while maintaining a relationship with patients, and where patients themselves feel better supported in a way that is more convenient to them, digital can play an important part in improving both capacity and quality of care. For example, remote monitoring has meant that in our anti-coagulation clinics, time has been freed up for those patients who most need to be seen face-to-face, while those being supported digitally have been able to improve self-management, with important health benefits. The service is popular with patients wanting to carry on with life as normal, taking and sending results at a time convenient to them but still feeling connected with the clinicians responsible for their care.

The barriers we have encountered include the behaviours and culture of staff. For clinicians used to working exclusively face-to-face, it is a considerable shift to support some patients remotely, and initially we found some distrust of digital. Absolutely key to overcoming this has been taking the time to explain how digital *supports* (rather than takes the place of) the clinical process and decision-making. This requires capacity building and training, and we have found that personal accounts of staff and patients are far more powerful than any statistics or data in



persuading people to work with the digital programme. Projects must be seen as clinically led, and not a 'tech' project, for people to really engage.

Another issue for our project has been the timing: digital needs to be a key part of discussions about new models of care but because the latter were still being developed, digital often felt like an add-on. We struggled to find the real clinical priorities and pursued perhaps too many avenues at first. Now that local plans for new models of care are becoming clearer, there are opportunities to be fed by – and feed back into – these plans, increasing the chances of our work on digital gaining traction.

In working with primary care, the lack of uniformity across practices has been challenging. This is where the national drive to develop primary care networks may bear dividends in the future. Operational pressures in primary care have meant that freeing up staff time to develop and test new digital products has been an immense challenge. This, combined with information governance, General Data Protection Regulation (GDPR) requirements and gaining patient consent, can all slow down the design process and limit creativity.

Looking beyond the health care system itself, we have struggled to integrate digital support into new homes and communities in ways that support health and wellbeing. People increasingly need to do their business online – including both residents accessing health information and staff accessing clinical records remotely. Hence we've been working with the Tees Valley Combined Authority to push for a pilot of free Wi-Fi access within an area of the town to test out the benefits.

So where does all this get us? In some ways the Healthy New Towns programme has only allowed us to scratch the surface of what's possible, but it has enabled us to build strong foundations on which to move forward. Our work as an early adopter has influenced the digital agenda more widely in the North East and Cumbria and helped to strengthen the regional digital infrastructure.

While we piloted 'digital' as an early adopter we also found that we were too small to do it alone; you need a collective desire, resources and capacity to implement and you need consistency of approach across partner organisations. This will be particularly important as we move towards working together in integrated care



partnerships under the umbrella of an integrated care system, with resources and strategy shared across local partners. This doesn't need to stifle the creativity of individual patches but it can bring benefits of quicker spread and adoption.

Whether in new towns or existing communities, embracing digital will be critical to create health care systems that are fit for the future. For us, one of the most important lessons is that digital cannot be imposed; it's about winning hearts and minds.



12 The role of developers in creating healthy places

Emma Cariaga

Emma Cariaga is Head of Operations, Canada Water at British Land, one of 12 founding members of the Healthy New Towns Network for housing developers and housing associations.

With more than 46 million people living in urban environments in the United Kingdom, the quality of places in our towns and cities significantly impacts our mental health and wellbeing. Research shows that people living in urban spaces are at almost 40 per cent higher risk of experiencing depression than those in the countryside, and they face higher levels of loneliness, isolation and stress. Whether we know it or not, the way urban environments are designed affects how we feel and what we do. As developers, we can have a positive influence on the use of our places and the impact on those who experience them today, and for the generations that follow.

Developers are responsible for the physical buildings and often the public spaces created around them. Very simple design interventions to buildings can make a dramatic difference to health. At British Land, we design buildings that encourage healthy choices – for example, rather than designing prominent lift lobbies we ‘celebrate the stairs’, making them centre place, easy to use and beautiful, and they become preferential to the lift. Aside from stairs in entrance lobbies, architects are increasingly designing ‘open staircases’ that nudge office workers to move around the building more often. As well as getting employees more active, serendipitous encounters around the stairs foster collaboration and encourage social connections, which can, in turn, increase productivity. There is therefore a benefit not only for the individual but also for their employer to encourage more physical activity among the workforce.



Outside of the buildings, our responsibility as developers extends to the open spaces we own and manage – often public spaces – where design can influence our emotions. People who are exposed to nature in the normally harsh city environment are not only more productive, but statistics show they also tend to be more generous, neighbourly and helpful. By creating friendly spaces, planting greenery and fragrant flora, we open up opportunities for more people to encounter nature in their daily lives.

However, perhaps our biggest opportunity yet to influence health outcomes is through our proposed new 53-acre town centre in Canada Water, in the London Borough of Southwark. It is with this development in mind that we joined the NHS Healthy New Towns Network, inspired by the opportunity to build a healthier place. The New Town centre will be situated in the heart of the former Docklands, surrounded by green parks and woodlands – and yet neighbouring areas have some chronic health issues, particularly around levels of social isolation and childhood obesity. Our development will strive to create a new urban location for more than 30,000 people working and living there, bringing together a range of uses (employment, retail, leisure, cultural, education and new homes) in a format that will encourage social connections.

At this scale of city planning we are focused at Canada Water on the ‘programming’ of spaces as much as their physical design. There is a role for the developer to not only create but also ‘curate’ these spaces and ensure that they are doing their best to contribute to the place and people that use it.

The issue of loneliness has a profound impact on mental and physical health and this development will enable those who live or work in the area or just visit to participate in activities that bring people together.

Rather than the usual ‘opt-in’ health initiatives, such as gyms, we want to create open environments designed for wellbeing that benefit 100 per cent of the people who spend time in them. We want to reintroduce the notion of facilitated sport or social activities that we all experienced when we were at school. In UK schools, and well into university life, Wednesday afternoons are protected for sports and recreation – and yet when we start our working lives, this all stops. Why? Across our New Town centre we will programme events and activities for everyone to



participate in. These are not compulsory, of course, but for those who choose to participate, they will help develop a sense of community and allow people to make connections. We are particularly interested in enabling events that allow for intergenerational relationships to be formed. With an ageing population and a New Town centre that will evolve over 10–15 years, we want to plan for the needs of a changing demographic.

Our involvement continues well after the buildings are completed and the homes, shops and offices have been let or sold. We are a long-term investor motivated by creating value through stable income streams. The success of our places depends on the quality of environment we create; as such, we take an active role in the management and curation of both the buildings and open spaces over the long term. This long-term approach is not typical, and many developers look to exit once the development is fully leased or sold. However, we believe that long-term stewardship is key to creating successful and resilient places, creating value for British Land and the community it provides for.

Ensuring that people do not get left behind is hard in new developments, and developers need to ensure that they develop and manage places that are inclusive and welcoming. As part of the NHS Healthy New Towns Network, we have heard first-hand of the brilliant initiatives running on many demonstrator sites and we have incorporated some of these principles to help shape our development at Canada Water.

We will, in conjunction with Southwark Council, develop a social charter to monitor the impact of our investment on the existing community and ensure a lasting legacy. This charter will help guide our investment into projects that focus on known challenges (many of which are health-focused) and seek to ensure we model the impact and recalibrate where necessary. We will feed our insight back into the NHS programme, working with health agencies and other government departments to influence further policy development.

Many of the actions proposed at Canada Water and NHS demonstrator sites are not new or novel. Initiatives that help people make and keep friends and stay active will go a long way to creating a successful healthy place. Living in urban environments can make these simple tasks harder and advances in technology



have, ironically, made us lonelier. As developers, we have at times focused on the aesthetics of design, but it is our role in ‘managing and making’ place that is increasingly going to be important.

At British Land, we invest in our places to make them the best they can be, and our business model means we stay involved over the long term to realise that value. We passionately believe in the value of good places, and in playing our part in the mission to ensure that we create places that help everyone become happier, calmer, more sociable and, ultimately, lead more fulfilling lives.



13 Discussion

In this section we reflect on some of the main lessons that national and local leaders can learn from the Healthy New Towns programme, drawing on the insights from our essay contributors as well as our own experience of supporting the programme. The section focuses on four themes:

- the role of national support in enabling transformation
- the value of taking a place-based approach
- working with communities in a different way
- new places as a test bed for integrated care.

The role of national support in enabling transformation

Finding the right role for national bodies in enabling transformation in local systems is a critical issue in public policy-making. The innovation programmes developed as a result of the Forward View involved NHS England and its partner organisations attempting to adopt a different, more facilitative relationship with local programme sites. For example, in our work on the new care models programme, Don Berwick of the Institute for Healthcare Improvement observed that the programme was ‘far more about release of energy than about central control’, although there was still some degree of tension between acting as a catalyst and playing a performance management role (Naylor and Charles 2018).

Getting this balance right has been all the more critical in the Healthy New Towns programme. As Laura Wilkes and Dan Northam Jones reflect in their essay, the programme involved NHS England going well beyond its natural territory, and as such there needed to be a ‘commitment to listening and learning’. Wilkes and Northam Jones write about empathy, humility and curiosity as being key characteristics that had to be embodied in NHS England’s relationship with demonstrator sites and external programme partners. In order to help planners and developers to create healthy places, health professionals first needed to understand their work and the constraints and incentives they operate under. The fact that



NHS England received far more applications to be part of the programme than expected indicates there is already considerable enthusiasm in the planning and development sectors for creating places that promote health – a conclusion which is also supported by survey data (Hunstone *et al* 2018). Part of the role of national organisations is therefore to build on this existing enthusiasm and remove any barriers to change encountered.

From a demonstrator site perspective, Rosie Rowe characterises the programme as having involved national ‘boundary-setting’ but with local determination of priorities, and argues that the programme’s flexibility was a critical factor in its success. In her experience, Healthy New Towns had an impact locally by acting as a ‘system connector’: the programme provided funding for a small team who were able to cut across organisational siloes, identify opportunities for collaboration, and support collective decision-making. These teams also played an important role in helping local partners to navigate the complexities around funding; agreeing how proposals would be funded was often one of the most difficult issues in demonstrator sites and the team needed the right skills to support this process. A key question for national organisations is who performs these connecting, facilitating functions in local systems during ‘business as usual’, outside of innovation programmes such as Healthy New Towns, and how to encourage the creation of such roles where they do not already exist.

The learning collaboratives set up through the programme were also widely acknowledged as a key vehicle for achieving impact. These created valuable opportunities for the individuals involved to share insights and to build relationships with their peers performing the same role in other parts of the country. Wilkes and Northam Jones argue that over time, these collaboratives took on a life of their own and became the route through which demonstrator sites collectively set ‘the agenda for conversations with the national team’.

An important lesson is that innovation programmes such as Healthy New Towns need to be designed in a way that helps participating sites to think long term and to try new approaches that might not deliver immediate results. This is particularly important in relation to creating healthy places; a three-year programme represents a small fraction of the time it takes to plan and build a major new development, which can often be 20 years or more. Kevin McGeough’s essay suggests that this is an area where more thought is needed, and that certain aspects of the national



programme meant that some decisions had to be based on what would deliver results within the lifetime of the programme itself. This echoes the experience of the vanguard sites that took part in the new care models programme (Naylor and Charles 2018).

The value of taking a place-based approach

One of the key insights emerging from the Healthy New Towns programme is that focusing on a place and the people who live in it can be a very powerful tool in designing interventions to improve population health. Demonstrator sites were able to develop an in-depth understanding of local communities and places, working in partnership across the agencies involved, with facilitation provided by the local programme teams described above. Crucially, this allowed multiple interventions to be delivered in a coherent and mutually supportive way. For example, this might involve creating some new physical infrastructure such as walking routes or green spaces, while at the same time working with local community groups to help them think about how they might make use of that new infrastructure, and also developing new models of care that emphasise supported self-management and connecting with community assets through social prescribing.

Demonstrator sites reported that some of the most impactful things they had done had involved combining multiple interventions in this way, with each intervention adding value to the others so that the whole becomes more than the sum of the parts. This kind of 'additionality' can only be achieved through a locally led, place-based approach as it depends on having deep knowledge of local services and assets. It would be difficult for a national blueprint to work in the same kind of synergistic way.

However, the way the national programme was designed did add to this synergistic effect by requiring demonstrator sites to work on several fronts at the same time, with plans for the built environment, community development and integrated care (see the Introduction). Bringing these three components together appeared to have been very helpful in that it added to the impact of the various interventions delivered.

In some cases, place-based working in demonstrator sites has led to a focus on tackling multiple risk factors simultaneously rather than designing interventions



targeting a single risk factor in isolation. For example, the healthy living strategy developed in Northstowe aims to create places that encourage social interaction and independence among older people while also supporting outdoor play and recreation for children and improving access to nature for people of all ages. Similarly, a series of evening events for families in Bicester were designed to help children and parents develop new interests together in relation to healthy eating, sports and a range of other activities.

Another important feature of place-based working in the demonstrator sites was that partnerships extended beyond the health and social care sector and involved other public agencies as well as communities themselves. For example, Rosie Rowe's essay describes how schools and local businesses were identified as key partners in improving the health of the population. Rowe also observes that in parts of the country where there is a two-tier structure for local government, district councils are an indispensable partner because of their local knowledge, their direct connection with communities, and the various resources they can mobilise in local neighbourhoods. Previous research by Buck and Dunn (2015) noted that links between district councils and the NHS are often underdeveloped, and this too was an experience reported by several demonstrator sites at the start of the programme.

One of the main benefits of participating in the programme reported by people involved was having the opportunity to strengthen relationships between agencies and to build a mutual understanding of each other's processes and timelines. Indeed, allowing sufficient time to develop this understanding was a key lesson from many of the 10 demonstrator sites. For NHS organisations, an important part of this was learning how and when to influence planning processes, and how to secure funding for new health care infrastructure through the development process (for example, through Section 106 agreements with developers and the Community Infrastructure Levy). There was a widespread view that at present, there tends to be insufficient experience of these matters within local NHS organisations, partly because responsibilities for NHS property and estates shifted from local commissioning organisations to NHS Property Services as part of the Health and Social Care Act (2012) reforms. The absence of relevant expertise in CCGs can mean that potential opportunities to pursue health objectives in new housing developments are lost.



Working with communities in a different way

Community development work has been a major focus of the Healthy New Towns programme, based on the evidence that strong communities can play a protective role in the health and wellbeing of residents ([Public Health England 2015](#)). Amanda Hill-Dixon's essay describes how this requires changing the relationship between residents and institutions to one based on partnership, with a willingness to share power and an acceptance that expertise comes from many sources, including local people.

Demonstrator sites have aimed to bring people together and to develop a shared vision of the future of the new place that the whole community can buy into. This has included organising community activities that are intergenerational and multicultural (encouraging intergenerational connections has also been a focus of attention elsewhere, as shown by Emma Cariaga's essay). In some cases, health promotion interventions have been deliberately designed to involve group-based social activities so that at the same time as encouraging healthy behaviours, they have helped people to build new relationships while also supporting positive social norms in the new community.

These principles are applicable to any community but can be particularly valuable in new places where community bonds have not yet developed and where there can sometimes be tensions between new and existing communities. For this reason, demonstrator sites have placed significant emphasis on bringing new and existing communities together and ensuring that any new health-related infrastructure being developed (such as walking routes) is accessible to people already living in the area and used by groups from all backgrounds. For example, as part of the Get Active in Ebbsfleet initiative, a digital app has been used to encourage new and existing residents to connect through games and challenges in public green spaces across the area. Similarly, work on healthy eating in Barton Park has aimed to make healthier food more easily available and affordable to all residents, in line with the programme's One Barton philosophy.

Demonstrator sites have attempted to take a strength-based approach, identifying local assets that could be used to promote health, and building on these wherever possible. Our research on the Wigan Deal has shown that when this kind of approach becomes embedded in the culture of local organisations and is applied consistently across the system, it can be transformative in its impact ([Naylor and Wellings 2019](#)).



In demonstrator sites such as Barton Park, part of this approach has involved catalysing small-scale community-led initiatives as a way of building capacity in the local voluntary and community sector (see the essay from Louise Upton and Joe McManners).

Working closely with community members has allowed demonstrator sites to gain deeper insights into the needs of the local population that were not visible in routinely available data (which, in the context of a new housing development, often fails to keep up with the rapidly evolving population). Virginia Pearson's essay provides one example of this in Cranbrook, where intelligence was sought from 'community anchors' such as a local minister and a school headteacher. Soft intelligence of this kind has proved a vital complement to quantitative data sources and can only come from having links into the local community.

New places as a test bed for integrated care

One of the original objectives for the Healthy New Towns programme was to use large-scale housing developments as a blank canvas on which new models of integrated care could be created and tested. Perhaps unsurprisingly, many of the elements of the care models developed in demonstrator sites are similar to those developed in some of the 'vanguard sites' involved in NHS England's new care models programme ([NHS England undated](#)). For example, there has been a major focus on connecting health care professionals with wider community assets through approaches such as social prescribing, link workers and health coaching. In line with the original intention, some demonstrator sites have been positioned locally as a test bed for innovation that can be used to inform strategic thinking in the wider local system.

Redesigning primary care has been a high priority in all of the demonstrator sites. The goal has been to enable GPs to work as part of an extended team incorporating a broader range of community-based professionals – essentially the same approach as that developed in the multispecialty community provider (MCP) and primary and acute care system (PACS) models in the new care models programme (see [Naylor and Charles 2018](#)). This has been very different from what has traditionally happened in new housing developments, where simple formulae are applied to calculate how many extra GPs will be needed to cover the new population, before then building one or more new GP practices on a conventional model.



The approach taken to general practice in demonstrator sites has been much more innovative and is closely aligned with the primary care home model ([National Association of Primary Care 2019](#)). It is also aligned with the new primary care networks launched by the NHS long-term plan, which aim to improve collaboration between practices and broaden the range of professionals working in primary care (see [Baird 2019](#)). It is notable that several of the contributors to this publication commented in their essays that they see primary care networks as creating an opportunity to advance their work on primary care.

Perhaps the most distinctive feature of work on integrated care in the demonstrator sites is the planned creation of new facilities designed to create a physical home in which the new model of care will (it is hoped) come to life. Demonstrator sites have regarded new facilities as being a significant enabler of transformation, and most have plans to build a 'health and wellbeing hub' (or similar) that will allow GPs to work alongside other health professionals while also creating spaces for activities provided by voluntary sector and community groups and potentially for leisure, library and other services. The exceptions to this are Barton Park, which has extended and adapted an existing facility to fulfil a similar function (see the essay by Louise Upton and Joe McManners), and Darlington, which has opted to link existing GP practices through virtual primary care hubs rather than creating new shared premises.

The planned health and wellbeing hubs offer enormous potential and serve as a physical metaphor for the programme as a whole – combining new built infrastructure with a focus on community development and on integrated care. However, designing them has been highly challenging, in part because the future needs of the local population are hard to predict and will change as the community grows and changes. Designing for maximum flexibility has therefore been critical.

It is also worth noting that previous experience has shown that putting multiple professionals and services together under one roof does not automatically lead to successful collaborative working ([Imison et al 2008](#)). To bring about genuinely integrated care in these facilities, demonstrator sites will need to ensure that there are ongoing efforts to redesign services and bring teams together beyond the opening of the new building, supported by an on-site manager responsible for integration.



Digital technology was also identified as a potential enabler of integrated care. Some demonstrator sites placed more emphasis on this than others, with Darlington being one site where particular efforts were made to adopt new technologies (see Hilary Hall's essay). In the main, these efforts were directed at the use of digital within health care pathways, with less of a focus on the role of technology in people's homes or in the community more generally. As Hall describes in her essay, digital is an area where the programme only scratched the surface of what might be possible. International examples of radical place-based digital innovation, such as Google's Smart City programme in one district of Toronto, give a glimpse of the opportunities that might exist in the near future (although some of the proposed applications of new technologies also raise privacy concerns – see [Scola 2018](#)).

As discussed in the essay by Irina Higginson and Clare Gibbons from Northstowe, contracting for new models of care has been a barrier in some sites, particularly the form of contract used for GP services. In the Barking Riverside demonstrator site, there are plans to develop an integrated care provider covering the new housing development that will hold a contract for primary care, community services, social care and mental health services, with GPs working as employed members of the wider team rather than independent contractors ([Serle 2019](#)). It remains to be seen whether a similar approach will be used in other demonstrator sites once the plans for integrated health and wellbeing hubs are further progressed.

Conclusion

Healthy New Towns has been an innovative programme that has illustrated there is significant potential to improve population health by focusing on the role of place-making and community development in health. It has also highlighted the very real risk of missing opportunities to improve health and care services if the NHS is not fully involved in development processes in areas where there are major housebuilding or regeneration schemes.

The programme has been a relatively brief intervention in the lifetime of the housing developments involved, but nonetheless has substantially altered the trajectory of their plans. Longer-term evaluation will be needed to determine whether this ultimately leads to improved health outcomes for the people who



live in these places now and in the future, and whether it succeeds in reducing health inequalities between different population groups.

Realising the opportunities for health improvement that the programme has highlighted means building stronger links between the NHS and local authorities, including parts of local government with which relationships are often underdeveloped, such as planning teams and district councils. Critically, it also requires having some form of dedicated resource in the local system that can act as a catalyst and connector – bringing together local partners and identifying opportunities for collaboration, and ensuring that there is a link between conversations at this level and strategic planning at other levels (for example, in sustainability and transformation partnerships).

Looking beyond the demonstrator sites, the real test of the programme’s long-term impact will be the extent to which the 10 Healthy New Towns principles are adopted elsewhere and used to ensure that other large-scale housing developments and regeneration schemes are used to improve population health and reduce inequalities in both new and existing communities. At a time when significant housing growth is needed, the opportunities to improve health at the same time as meeting the country’s housing needs are considerable.



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About the editor

Chris Naylor is a Senior Fellow in Health Policy at The King's Fund. In 2018 and 2019 he led The King's Fund's involvement in the Healthy New Towns programme as a support partner to NHS England. Chris contributes to The King's Fund's work on integrated care and health system reform, and has particular interests in mental health and the relationships between people, place and health. He holds an MSc in Public Health from the London School of Hygiene & Tropical Medicine and a BA in natural sciences from the University of Cambridge. He has previously worked in research teams in a number of organisations, including the Institute of Psychiatry and the Public Health Foundation of India in Delhi. He is also an executive coach and works with leaders in the health system to support change at the local level.



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The places we live in have a profound impact on our health and wellbeing, but the joined-up thinking needed to create places that support and promote health can be challenging to bring about. NHS England's Healthy New Towns programme has sought to overcome this by bringing together the health sector, housing developers and local authority planning teams to design and build healthier communities.

Creating healthy places: perspectives from NHS England's Healthy New Towns programme provides personal insights from those involved in the programme, illustrating how powerful a coherent approach to improving population health can be. It highlights the importance of a number of themes, including:

- the value of taking a place-based approach to population health, making the best use of local assets
- the need for specific action on health inequalities to ensure that efforts to create healthy places benefit groups at highest risk of poor health outcomes
- the importance of working with communities and bringing together the residents of new places with those living in established neighbouring communities
- the potential to use new places as a test bed for integrated care, in particular for new approaches to primary care.

The report concludes by highlighting that there is significant potential to improve population health through place-making and community development. It also stresses the need for the NHS to be closely involved in major housing developments and regeneration programmes in order to improve health and care outcomes.

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