THE HEALTH CREATION ALLIANCE'S RESPONSE TO NHS ENGLAND AND NHS IMPROVEMENT'S CONSULTATION

"INTEGRATING CARE: NEXT STEPS TO BUILDING STRONG AND EFFECTIVE INTEGRATED CARE SYSTEMS ACROSS ENGLAND"

08 January 2021

About The Health Creation Alliance

The Health Creation Alliance is the only national cross-sector movement addressing health inequalities through Health Creation. You can visit our website here: www.thehealthcreationalliance.org

Up until 1st January 2021, the organisation was known as New NHS Alliance. The change to The Health Creation Alliance brings the organisation's name into line with its core purpose and Community Interest Company established two years ago. The new name also better reflects the focus and the multi-disciplinary nature of its membership, programmes and support. Here is a press release from last October announcing the name change: Name-change-press-release-FINAL- -22-October-2020.pdf (thehealthcreationalliance.org)

Our mission is: ***to increase the number of years people live in good health in every community***.

Members of The Health Creation Alliance are people who want to see this change happen across our health and care systems. They are drawn from the NHS, local authorities, housing and other statutory services such as policing, fire service and education, the voluntary and community sector and people with lived experience of disadvantage and poor health. They join the The Health Creation Alliance for free and contribute to the advancement of Health Creation across our systems.

We have recently undertaken a series of multi-stakeholder events supported by NHS England and NHS Improvement exploring the question '*How can Primary Care Networks, communities and local partners succeed in addressing health inequalities?*' We will publish the final report by mid-January and we would be delighted to forward a copy to support this submission.

We would be very happy to have further dialogue to explain our feedback and to support a more sustainable shift towards Population Health Creation. Please contact CEO Merron Simpson on merron@newrealities.co.uk

General comments about the consultation

We welcome the significant efforts being made to transform the health and care system into a place-based system through Integrated Care Systems (ICSs). In mapping out some 'next steps' in the context of the NHS Long Term plan, the consultation paper demonstrates good intentions to simplify the bureaucracy and shift systems into a more collaborative space working with local authorities and other local partners. In principal, we support the devolution of powers from national level.

Good ICSs that understand the potential for Place-based Partnerships and that are prepared to make the significant investment to shift their systems to work coherently with local authorities, communities and local partners and to focus on population health and wellbeing (not just healthcare) will be able to do so through the measures being proposed. The good ones will be ready to use the devolved powers well.

However, there is nothing within the proposal that will **require** ICSs to take this journey and the introduction of Provider Collaboratives could mitigate against the emergence of strong Place-based Partnerships. It lacks sufficient checks and balances in the form of governance and accountability to the local population. The proposal needs to go further to define Place-Leadership arrangements – or to require ICSs to define them – in such a way that they will be sufficiently strong to address health inequalities and deliver health outcomes across the whole population.

Because of this, we believe it falls short of a realistic plan for addressing health inequity/inequalities which requires coherent place-based working. ***We therefore cannot support putting ICSs on a statutory footing until the issues we raise in this consultation are responded to.***

It is clear that the NHS must prioritise action on health inequalities in the wake of COVID-19 (see Sir Michael Marmot's latest report, Build Back Fairer[1]). This means prioritising collaborative working with local partners who are also seeking to address health inequalities from a socioeconomic perspective including socially excluded groups (such as homeless people), those with specific protected characteristics (such as disability or ethnicity) and people who are disadvantaged because of where they live. If health inequalities are not prioritised, then demands for acute care will continue to grow presenting an even greater needless burden of on health and care systems.

At the heart of the concerns we have with this proposal is that it introduces a new tension in the system – between Provider Collaboratives and Place-based Partnerships. While this consultation describes them sitting side-by-side, from our deep experience of supporting the emergence of cross-sector collaborations we simply cannot envisage how, in reality, they will be compatible in many places. The 'system power' will sit with the providers rather than the partnerships; however, Place-based Partnerships need to be supported to develop into coherent, powerful, health creating collaborations and they need to be the principal driver of what happens in a place. The balance of power needs to be tipped towards Place-based Partnerships.

Here's what a North-West London GP, who participated in a project we are engaged in, said about his experience of the existing system during COVID-19: *"I felt completely removed from the networks I was in and sucked into a system. It created a tension between the networks and existing hierarchies".*

[1] Build Back Fairer: …

It is clear that Provider Collaboratives will be dominated by the very large providers. As traditional commissioning diminishes, small, niche and community-based providers risk being frozen out from playing their part even though they can often deliver much better outcomes through responding well to local needs and drawing out and developing local assets (the contributions from individuals and communities). Dominance of the large players at ICS level will remove agency from the frontline – in this sense, it doesn't actually deliver on the promise of devolution. We suspect the kind of tensions expressed by our GP member will increase.

It is also clear that this consultation reflects mainly NHS leaders' experiences over the last two years. It is far less reflective of the experiences of other place-based partners, such as local authorities (including social care, health visiting, public health, communities teams), housing, community pharmacy, the VCSE sector and communities themselves. The community layer is almost entirely missing despite communities having demonstrated huge capability and capacity for taking charge, responding to a crisis, keeping people well and for sustainable Health Creation (over many years and recently through the first COVID-19 lockdown).

The NHS must start to value and respond well to increasingly networked communities in a post-COVID-19 world – to work with them as equal partners in health creation and support them for example though commissioning community businesses and providing funding for community strengthening. This aspect is missing from the plans.

How it could work – a health creating, place-based approach

We want to respond positively to the consultation.

Being a cross-sector movement, spanning NHS and non-NHS parts of the system, we know that many people across many sectors and communities outside the formal NHS are fully bought into the processes involved in addressing health inequalities. They are supporting individuals and communities at all ages to have better physical and mental health and a good life. Our 2019/20 event series on Primary Care Networks and health inequalities concluded that: *Lasting reductions in health inequalities will only be possible through working in genuine partnership with communities… by seeing them as part of the system and a significant part of the route to lasting solutions.*

In our detailed response, we are therefore focusing on a place-based approach and structure that would harness this energy and desire for better health outcomes from across all sectors and communities and increase activity on prevention and Health Creation within places. We are calling this Population Health Creation. What we are effectively talking about is harnessing a place-based 'army' to take some of the load away from the NHS and reduce demand for its services.

In the box below we describe what we mean by Health Creation and health creating practices.

We would like to see ICSs, PCNs and other place-based partnerships adopt Population Health Creation approach alongside Population Health Management. We would like DHSC, NHSEI and PHE to get behind such a proposal.

Health Creation and the features of health creating practices

Enabling people to increase their levels of **control** and **confidence**, through meaningful and constructive **contact** with others, helps to build protective factors and keeps people as healthy and productive as possible. Control, Contact and Confidence are the 3Cs of Health Creation: they characterise communities that been most resilient during COVID-19. Alluding to them, Prof Marmot says: *"To tackle inequality, society needs to enable all children, young people and adults to maximise their capabilities and have control over their lives".*[8]

Professionals can help to create the conditions for people and populations to be well by adopting and embedding the 5 features of health creating practices within everyday practices and through health systems. These five – Listening and Responding, Truth-telling, Strengths-focus, Self-organising and Power-shifting – are the things that communities consistently say makes the biggest difference to them: these are the 'active ingredients' of Health Creation.

Integrated Care Systems need to adopt a Population Health Creation approach throughout their systems alongside Population Health Management.

Our detailed response

Para 1.15 – add Health Creation to 'offer to the local population'

We welcome creating an 'offer to the local population in each place'. We strongly recommend adding assurances around Health Creation and accountability to this offer so that in every place everyone can expect:

- A regular conversation and feedback at the PCN level between ICS decision-makers, community members, other local partners and PCNs about health in their place – in a venue chosen by the community.
- A commitment from the ICS to invest in relationship-building to develop strong networks between members of local communities (for example by employing community development workers) between health providers and local communities and between health providers and other local partners.
- To be enabled and supported – as an individual and a community – to become and stay well through the adoption of the features of health creating practices across the health and care workforce.
- To be supported to play a role, or roles, within their community to support the Health Creation effort to keep people well.
- Access to relevant pathways through which individuals and households can receive help to address their wider social and economic needs, attending to the social determinants of health as well as medical need – this is in addition to social prescribing.
- Better representation of communities and local partners on the ICS boards and within Primary Care Networks.

Para 1.16 and 1.17 – Value communities and the contribution they make

These paragraphs miss the roles that communities themselves (apart from the voluntary sector) play in creating health and how the connection will be made with them. For example, some community centres have over 2,000 people per week coming through their doors. Some have treatment rooms where low level health appointments could take places. *"We can easily get a crowd of 60+ people to a meeting if someone from the health centre came to explain to the people what the changes are and how it works – such as E-Consult"* Community Centre Volunteer, Plymouth.

Para 1.21 – Pathways through Place-based Multi-Disciplinary Teams

We agree that there is a need to harness the involvement, ownership and innovation of clinicians, working together, and with place-based partners, to design more integrated pathways through which people can access support for their wider social and economic needs. These pathways would be made available through 'Place-based Multi-Disciplinary Teams' involving many sectors and which have been described by one local authority as 'Multi-Disciplinary Teams on steroids'

Paras 2.4 to 2.16 – Continue commissioning small and community providers

We have concerns that **Provider Collaboratives** as described will only include the very large providers and will effectively freeze out smaller and niche providers from playing their part even though they may, in fact, be able to achieve much better outcomes.

Combined with the 'single pot' into which the current commissioning budgets will be placed, we do have concerns about the direction of travel of the money and the potential for place-based and community-based forms of support and Health Creation to become marginalised.

While the current commissioning arrangements are not perfect, they do allow commissioners to become familiar with the wide range of potential provision in their areas that support prevention and Health Creation and to innovate to shape the market and diversify the types of provision and providers. If anything, commissioning needs to become more responsive to the voluntary sector, community businesses and communities groups themselves. Our concern is that ICSs will be less (not more) likely to work with the community and voluntary sector than is happening through the current imperfect commissioning arrangements.

Our deep concerns with the proposed new approach is that it will strongly favour the very large providers even though they are rarely best-placed to succeed in prevention and Health Creation. It is important to continue commissioning organisations that can meet specific or local needs in a way that values relationships – something we know is highly important in creating health.

Paras 2.17 to 2.21 – Strengthen the framework for Place-based Partnerships

We are very much in favour of strong and effective **Place-based Partnerships.** However, it's not clear how they will work alongside Provider Collaboratives. We sense there will be tensions and competition for resources and that without a stronger framework to tip the balance towards Place-based Partnerships, they will lose out to Provider Collaboratives in many places whenever the acute services are under pressure (which will be for a long time). It is going to be necessary to take some difficult decisions over the coming years and to prioritise action on prevention and Health Creation through place-based partnerships in order to reduce demand for NHS services over time.

In para 2.18 we would recommend adding a 5th role to the place leader:

- To adopt Population Health Creation (alongside Population Health Management) within a vision for health and wellbeing in the place. Health Creation focuses on connecting and building relationships as the key driver of improved health while health management focuses on data and evidence to identify where problems lie. Communities can often tell you the reasons behind what the evidence is showing and they can support development and deliver of solutions to the problems identified by the data. The continued lack of recognition of the need for 'Population Health Creation' alongside Population Health Management is compromising progress on health inequalities and holding people who live in disadvantaged places back.

This means:

- Adopting the five features of health creating practices at the frontline and providing flexibility across health systems to respond
- Investing in 'connection' to build effective relationships between place-partners and with communities
- A community development presence in every place – especially those places with low levels of social capital (connections between residents)
- Promoting community-leadership

Paras 2.22 and 2.23 – NHS in equal partnership with local authorities

This section on **The NHS's offer to local government** is not at all clear what is required. We propose this is reworded – with input from the LGA and other local authorities – to demonstrate a more equal relationship between the NHS and local authorities who have many population health functions, not least that they are responsible for care of our ageing population and have a large bearing on preventative measures to delay older people requiring both care home provision and healthcare.

Paras 2.24 and 2.25 – PCNs as cross-sector groups

The best Primary Care Networks are an umbrella organisation to which all local partners can come and they are a place where clinicians can connect. The process of building relationships needs to be invested in, but only clinical roles are allowed in the Additional Roles Reimbursement Scheme (ARRS). As one or our Health Visitor members recently said '"The activities involved in 'relationship building' are not sufficiently costed into the model"

Until they are, we believe most PCNs will struggle to engage effectively with their communities and local partners.

We will forward a report in the next few days from our recent multiple-stakeholder events that asked the questions *'How can PCNs, communities and local partners succeed in reducing health inequalities?*'. We will be publishing another report shortly that goes further to answer this question in a post-COVID-19 world.

Paras 2.28 to 2.38 – Include informal leaders in ICS governance

We agree that 'ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities'. However, the lists provided in para 2.31 are not expansive enough in terms of the breadth of local partners mentioned.

The proposals for governance need to ensure that informal leaders are included as standard alongside formal leaders in the system, so that they can build relationships across formal and informal services and join their offer together. This is the whole point of having place-based approaches – so that informal community groups can organise well and in collaboration with the formal services to support Health Creation and prevention. If this doesn't happen, then both the NHS and local authorities will be missing a key part of the jigsaw of how to keep their populations well.

There are some outstanding leaders in the community and voluntary sector and ICSs need to hear about the experiences from the community perspective on a regular basis if they are to get this right. Including community and voluntary sector representatives within the leadership at this level will support wholesale transformation of the way systems work – for the better.

'Healthwatch' is not sufficient as a representative of either the patient or community voice. We recommend requiring all ICSs to include a community representative on the place-leadership group as standard. We also recommend the voluntary sector leader to be represented as standard, on all ICSs.

We also recommend including housing, fire service, police, schools and community pharmacy within the list of sectors that 'They may flexibly define' in para 2.31. Ideally, all ICSs would include these within their place leadership arrangements.

We agree that ***one of*** the local tests for these governance arrangements is whether they enable joined-up work around a shared purpose. However, this is an interim goal (Para 2.33). ***The final test must be whether they enable people to have better health and to live a better life and whether they are successful in reducing health inequalities over time.*** This will be much more likely to be achieved through involving communities themselves, voluntary sector and housing organisations who have lots of experience in improving health and wellbeing and addressing health inequalities.

We agree that provider collaboratives and placebased partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services (para 2.33). This must include informal services provided by smaller providers, social enterprises and the VCSE sector because this is where the innovation is happening around shaping services that work for communities and help to reduce health inequalities.

Para 2.38 is too poorly defined. We recommend that ICSs should be required to define, within their place-based arrangements how it will work with local democratic structures -

citizens' panels, local health champions, co-production groups as well as how they will reach excluded groups – to draw on community insights and to inform decision-making. They also need to explain arrangements for feeding back and ongoing dialogue with these groups, since feedback is essential for trust-building. There needs to be a way to hold ICSs that don't do this to account.

Paras 2.39 to 2.48 – Devolve health resources to community group

See our concerns about the commissioning budget being placed into the single pot set out in our response to Paras 2.4 to 2.16.

Creating the 'single pot' at ICS level has the effect of centralising (and not devolving) resources. It will have the effect of taking decision-making further away from communities and populations.

If it is decided that the single pot is the way to go, then it will be important for ICSs to be required to devolve a proportion of the health budget to the very lowest level ie. to communities to develop Community Health Creation. This could include dedicated relationship-building roles with and in the community such as community development and community strengthening roles. This could be a small proportion such as 1% in 2021/22 rising by a small percentage each year perhaps to 3% by 2026. Communities need to be invested in, in order for the community effort to be sustained and capacity for Health Creation built.

Paras 2.49-2.52 – Work with other local partners to address digital exclusion

In para 2.49 we recommend adding a 5th bullet to the list – one that systems will need to address if they are to succeed in reducing health inequalities:

- Address digital exclusion among patients, people and communities

This is because there are still many people who don't have digital access either because they can't afford a laptop, tablet, smart-phone, broadband or contract or because they don't have the know-how or confidence to adopt digital. While there are some that don't want to make the effort, they are relatively few who wouldn't try, given the right support.

The pandemic has accelerated the 'channel shift' and people are being left behind.

When it comes to 'putting the citizen at the centre of their care', digital inclusion is certainly important. However, 'self-care' / health creating activities such as attending leisure activities, talking to friends and relatives also need to be accessed by digital means such as Zoom so it is important that everyone now has access to digital, but that face-to-face appointments are also built back into the mix when pandemic conditions allow.

ICSs can work with others to address digital exclusion. Housing providers (who are landlords to over 10 million of the UK's residents living in the more disadvantaged areas) have been working to get their tenants online for the last 10 to 15 years … they could make great partners in this endeavour. Community groups can also be partners in making sure residents have access.

Our answers to the four specific questions posed by the consultation

Note: these have also been uploaded to your website system for responding.

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Only if our concerns are responded to – we have provided a positive alternative for ICSs to adopt Population Health Creation across their systems, alongside Population Health Management.

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We do not have a strong opinion for either Option 1 or Option 2 as a route to enshrining ICSs in legislation.

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

There needs to be some flexibility. However, we consider it is necessary to specify 'community representatives' as required in addition to NHS bodies, Local Authorities and Healthwatch.

In addition to the high-level membership of the ICS, we believe the legislation should require all ICSs to establish a sub-group of Place-based Partners – The Place-based Leadership Group – whose remit it is to deliver health creating, place-based working across the ICS geography. They should report to the main Board and their success should be measured through both long-term health outcomes and short-term proxy's for health outcomes such as 'Social Capital' – the connectedness of communities (since there is plenty of evidence to show that being connected is good for your health).

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

We cannot support delegating these powers and putting ICSs on a statutory footing until the issues we raise in this consultation are responded to. The balance of power needs to be tilted towards the Place-based Partnerships and Population Health Creation; these proposals fall short of achieving that.

If the well-grounded proposals we have set out in this consultation response are adopted then we would embrace devolution of power much more enthusiastically.

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