Health Creation:

Addressing national health inequalities priorities by taking a health creating approach

A report from a webinar hosted by The Health Creation Alliance

Acknowledgements

We are very grateful to NHS England and NHS Improvement for their sponsorship of the webinar entitled: *A health creating approach to addressing health inequalities across Integrated Care Systems* that was held on 28 September 2021.

Introduction

Addressing and reducing health inequalities has been a consistent ambition of the NHS for many decades. In 2019, the NHS Long-Term Plan made tackling health inequalities a clear national priority. Together with the NHS Policy Paper, Integration and innovation: working together to improve health and social care for all, and its commitment to place-based working, there is now a huge opportunity for fresh approaches to addressing health inequalities, that have been brutally exposed by the COVID-19 pandemic.

Integrated Care Systems (ICSs) have a critical role in creating the conditions for new partnerships to coalesce and in fashioning new approaches and pathways that embrace the wider determinants of health and resonate better with people's lived experience.

ICS Guidance published in September 2021 contains ten principles for working with people and communities to build strong ICSs everywhere because "COVID-19 has underlined how health inequalities can only be addressed by listening to and understanding the people we collectively serve". They are similar to the Building Back Together Ten Key Messages published by The Health Creation Alliance in April 2021.

Health Creation offers an approach and frameworks for thinking through and applying new ways of working to create the conditions for people to be well and to change systems, enabling more equitable access to, better experience of and optimal outcomes from health, care and wellbeing services.

This event focused on the five priorities for addressing health inequalities identified by NHS England and NHS Improvement and that ICSs are required to address. They are:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are complete and timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthen leadership and accountability

The event showcased examples of clinicians forging health creating approaches that address each of these five priorities. It also explored steps ICSs can take to adopt and embed Health Creation as a route to a long-term, sustainable approach to addressing health inequalities

"We cannot treat our way out of ill health. If we don't harness the system, work with the power of employers, networks and communities, health inequalities won't improve".

Jim McManus, Director of Public Health, Hertfordshire County Council and Acting President, Association of Directors of Public Health

About The Health Creation Alliance

The Health Creation Alliance is the only national cross-sector network addressing health inequalities through Health Creation.

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

We achieve this by: connecting the voice of lived experience to people setting the policies and designing systems and services; drawing on our members' extensive connections to bring together movements and collaborations that energise and empower professionals and local residents to take action; helping places to establish 'Health Creation communities of learning', bringing together professionals from diverse backgrounds, community members and people with lived experience to learn from each other.

We also seek to increase the profile and status of Health Creation with national policy makers, systems leaders and practitioners as an essential part of the fight against health inequalities.

You can join the The Health Creation Alliance for free and become part of the movement: Members | The Health Creation Alliance

Key messages emerging from the event

1 Restore NHS services inclusively

- Work as equal partners with communities and other local partners in places and neighbourhoods: ICSs and their constituent parts must do this if they are to succeed in addressing health inequalities
- Adopt a single framework for working with communities and use it consistently. An effective framework will start by listening to communities to gain insight into the challenges, what's working and potential solutions, and it must include handing power to local communities
- Connect with those who already have the reach within communities and work with them to engage with others within those communities. Building on and growing trust is the only way to undertake genuine listening, gain insight into the challenges and the opportunities so that you can respond with services that work for people.

2 Mitigate against digital exclusion

- Talk to the people who you want to access your services about what will work for them in terms of digital and other forms of access – don't force them to use digital communication methods
- Reach out to patients through the platforms they already use; make an emotional connection
- Offer blended access options, including face-to-face consultations
- Connect and work with third sector providers already addressing digital exclusion – work with them to expand and enhance what they're already doing
- Help people to develop digital skills to enable them to do what they want to do, such as communicating with friends and completing benefit forms online – that will help to secure their engagement in online NHS services

3 Ensure datasets are complete and timely

- Datasets will only be complete if they include the insights from and reflect the perspectives of communities. Community insight is needed to inform effective decision-making
- Give legitimacy to the stories people share; parity of esteem between community narratives and quantitative data will support evaluation of programmes
- Use data to inform the formulas you use for allocating funding and make sure those data include indicators of poverty, deprivation, social injustice; because poverty is a real driver of health inequalities. Also use data:
    - to change the conversation you're having with your communities
    - to empower your teams to work differently
- Triangulate datasets by combining data from many partners to provide a more comprehensive view of your communities needs. Share this:
    - with citizens; they need to know about the gaps in health and wellbeing and they will help deepen understanding of what is actually happening
    - with clinicians to draw out their insight and perspectives

Key messages emerging from the event

4 Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

- Find 'proxy markers' in triangulated datasets – such as free school meals, assisted bin collections, English as a second language, house condition – to identify and reach the people whose lives are most impacted by health inequalities
- Connect service providers with communities to have a different conversation
- Facilitate community-led provider-citizen collaboration where appropriate. Listen to people and treat them as equal partners
- Co-create solutions with communities, because ideas that come from people will work for them
  - be humble
  - don't impose your assumptions and ideas on them
  - build their strengths and enable them to lead
- Recognise that each community is unique; the solutions may also be unique to them
- Measure what people value – because they're not motivated by system targets

5 Strengthen leadership and accountability

- Be prepared to bring your personal selves into conversations with communities and share aspects of your experience, because that's what we're asking others to do
- Give the workforce permission to try new things and develop new solutions in partnership with communities
- Get behind those at the frontline who are actively working in new ways and developing new solutions with communities; ask them what's working and how you can support them to develop their approach further and spread it
- Embrace 'social movement' as a legitimate way of working with your communities and your workforce; don't be afraid if this stirs up anger and passion in your communities
- Challenge inevitability; create moral alternative economies
- Broach an honest conversation with senior system leaders about how to allocate money more fairly – to spend more in places with the greatest social injustices and poorest health outcomes

"Too many ICS/ICPs have a top-down, command and control, KPI focused… where leaders are not exposed to real people. The more leaders can get out there and listen to communities the better".

Prof Donna Hall, CBE, Chair of New Local, Chair Bolton NHS Foundation Trust

Health Inequalities Priority 1: *Restoring NHS Services inclusively*

The National Perspective

Dr Bola Owolabi, *Director of Health Inequalities, NHS England and NHS Improvement*

The vision is to deliver exceptional quality healthcare for all by ensuring equitable access, excellent experience and optimal outcomes

This will need development of the role of the NHS as a partner within the ICS, working with local authorities, Health and Wellbeing Boards, voluntary sector partners and community action organisations.

These partnerships are vital to ICSs delivering on their core purpose:

- Improve outcomes in population health and healthcare
- Tackle inequalities in access, experience and outcomes
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

This event provides a platform for panel members to share their expertise and insight into how Health Creation can help deliver on the five priorities for addressing health inequalities identified by NHS England and NHS Improvement. It is hoped that this will energise and help equip attendees with the insight to build the genuine collaborations necessary to achieve our common purpose of narrowing the gap on health inequalities.

A Place Perspective

Jim McManus, *Director of Public Health, Hertfordshire County Council and Acting President, Association of Directors of Public Health*

There is a need to take a whole system view, so that the system and the place revolves around people and communities – as oppose them having to find their way into the system

We cannot treat our way out of ill-health and we need to work with the power of employers, networks and communities. As 80% of health outcomes are not shaped by healthcare itself, what we do as a system and at the place level should therefore be our first consideration.

In fact, if we don´t harness the system, we won´t be able to address health inequalities. In harnessing the system we need to listen to, and share power with, communities and this needs to be done with a degree of humility.

Communities also need the NHS and LAs to clarify with them their approach to community engagement and collaboration. Ideally, this should focus on a single framework that everyone sticks to, as oppose constantly changing processes. An effective framework will start by listening to communities to gain insight into both the challenges and what's working, and it must include handing power over to local communities

Summary of the Health Creation framework

Building meaningful and constructive **Contact** between people and within communities increases their **Confidence** which leads to greater **Control** over their lives and the determinants of their health.

By adopting and embedding the six features of health creating practices as a way of working. practitioners can become equal partners on the things that matter to people and communities.

- Listening and responding
- Truth-telling
- Strengths-focus
- Self-organising
- Power-shifting
- Reciprocity

A Communities Perspective

Samira Ben Omar, *Head of Engagement and Partnerships, NW London Clinical Commissioning Group*

Communities play critical roles in creating health. We need to connect with communities around a different type of conversation to transform the way we deliver health and care services – particularly around health inequalities

If we're asking communities to share aspects of their experience, we need to be prepared to do the same – moving beyond being a representative of an organisation only, to being a representative of our personal self.

Outreach to the community should start with connecting to those who have the reach into communities. These will be different in every place and it is a good starting point to collectively going on an iterative journey with communities through a series of conversations.

Adopt social movement principles to have conversations with local people (where the system perceives that people don't want to engage) where one conversation will lead to another. This will enable different designs for each community hub to mirror what is needed in that place.

Give legitimacy to the stories people share in the way they are told, and avoid interpreting what is said so that it fits into what a system wants to hear.

Learning from a Community Champion´s Programme:

- People do more when they decide for themselves; they are not motivated by system targets but by something different
- Community and face-to-face are the lifeblood of local action; invest in it
- Structural racism and wider inequalities have a negative impact on health and wellbeing; start acting on these things
- Measure what people value using social return on investment; the system can still deliver the things it needs to while also delivering what matters to people

By giving parity of esteem to these stories, evidence can be created for a different way of doing things. This, in conjunction with quantitative data can help evaluate projects where the data doesn't provide the whole story.

"Communities have been there for generations; it's us that are new and are hard to engage with".

Health Inequalities Priority 2: Mitigating against digital exclusion

Dr Talac Mahmud, *GP, FirstCare Practice, Hounslow*

Dr Chad Hockey, *Board Director and CEPN Clinical Lead, Hammersmith and Fulham GP Federation*

Digital is just one of many communication channels and people mustn't be forced into using it. People should be given a choice. By helping those that want to use digital use it, it frees up more time for face-to-face contact with people that don't

Trying to work to a systems-defined standard set of criteria with funding to meet set health inequalities challenges, presents a tension for GPs working at the 'Deepend' of health inequalities. People in these neighbourhoods are facing different challenges from the systems is designed to address.

A good example of this is e-Consult not meeting the needs of many people because the algorithm doesn´t compute the complexity of their lives. Also, many people can´t get online. This begs the question: "How can you improve access to care by implementing a digital consulting tool, without involving the people who are going to be accessing care?" When asking people about e-Consult, many were saying "Can we do this face-to-face please?"

People who are digitally excluded should be connected to third sector organisations already addressing this. In addition, a skills framework and curriculum should be co-produced. This must go well beyond accessing general practice and include things such as helping people to communicate with relatives, or complete online benefits forms. By engaging with people through something that is important to them, their engagement in online NHS services will be enhanced.

ONS statistics show that 15% of the population use health apps while 70% use social media. So, use those platforms that patients already use and speak to patients in a language they're familiar with to make an emotional connection.

By giving parity of esteem to these stories, evidence can be created for a different way of doing things. This, in conjunction with quantitative data, can help evaluate projects where the data doesn't provide the whole story.

"Other industries – banking, supermarkets – haven't forced people into a digital route; gentle nudges rather than mandates. The NHS needs to focus on what you're trying to achieve rather than focusing on the means of achieving it".

Health Inequalities Priority 3: Ensure datasets are complete and timely

Dr Andy Knox, *Director of Population Health and Engagement, Bay Health and Care Partners in Morecambe Bay, Executive GP for Morecambe Bay CCG*

People want to see the data and then to help to interpret it to explain what's actually happening

Two key steps to creating and using data

Data alone tells us little. Data shared with community, combined with time and resource, creates projects together that begin to change the narrative, proves that things can be done differently together and empowers teams to work in new ways.

STEP 1. Triangulate and layer data from multiple sources e.g. general practice, acute trusts, district/county council data, Public Health England to provide a rich tapestry of data. Include data to make sure that you´re reaching the people whose lives are most impacted by health inequalities e.g. free school meals, people who have English as a second language, house condition and assisted bin data, an indicator that people have complex needs.

STEP 2. Rather than designing projects, sit with the communities and share and interpret the data. Listen to what they have to say and let them realise that it doesn´t have to be this way, then work as equals to co-create solutions that drive change.

"We should all consider talking about an Index of Multiple Social Injustice, as oppose an Index of Multiple Deprivation, to help shift resource and funding into those areas".

Health Inequalities Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

Dr Gillian Orrow, *Community Development Clinical Lead, Healthy Horley Primary Care Network, Programme Director, Growing Health Together*

Delivering place-based approaches to preventing illness and creating health within communities is a journey

Place-based approaches start with listening to and collaborating with citizens, local government, schools, the VCSE sector and other local agencies.

It also involves:

- understanding the social determinants of health and appreciating that most health outcomes are influenced by factors outside of healthcare, that healthcare behaviours are influenced by these factors and that they all need to be taken into consideration when creating health
- providing protected, funded time for GPs from individual PCNs to be actively involved
- recognising that each community is unique and will have different dynamics and needs
- a shift from a top-down institutional based model to a place-based, inclusive approach

Some principles behind the Growing Health approach:

- Connect service providers with citizens, as equal partners
- Deep listening – gaining huge insights from citizens about the challenges – also finding out what's already strong and is working
- Enabling community-led responses
- Facilitating provider-citizen collaboration where appropriate

Our community led support group for carers and those they care for with dementia

Health Inequalities Priority 5: Strengthening leadership and accountability

Donna Hall, *CBE, Chair of New Local, Chair Bolton NHS Foundation Trust*

This is not about implementing a set of rules from NHSEI at pace and scale, it's about asset-based, human to human connected leadership based upon compassion and it starts with integration from the bottom-up

There is a need for a different type of leadership and 'heroic' leadership needs to be challenged; repeating the old ways of ´silverback' type leaders will inevitably fail.

The starting point must be recognising that the current system is broken, and ICS´s cannot be expected to transform the outcomes without working with and engaging communities.

Too many ICS/ICPs have a top-down, command and control, KPI focused approach where leaders are not exposed to real people; they have an assumption about how people live their lives that is not based on reality. They don't listen, they don't get out there, they're hermetically sealed. The more leaders can get out there and listen to communities the better

Leaders therefore need a different skill-set to work with communities in an effective and joined-up way. They need to get out and listen to communities and recognise that systems leadership is different from the role in leading organisations – good organisation leaders are not necessarily good system leaders.

Leaders need to lead deep-seated culture change, listening and learning from local communities.

Leaders also need to be tight on outcomes but loose on how programmes are delivered because every place is different. This necessitates funding allocations being based on poverty, deprivation, social injustice rather than just treating everyone as though they're on a level playing field… because poverty is a real driver of health inequalities

How might NHS England and NHS Improvement create an enabling culture for ICSs? Here's what panel members said:

There are a set of principles underpinning what ICSs need to deliver. If adopted they would drive a change in culture. NHSEI needs to enable the culture change by applying/embedding the principles from today and saying "ICSs, you must do x, y, z".

To some extent, ICSs are still a conduit to translate central strategy. A lot of ICSs aren't activated yet and are not making these decisions for themselves. NHSEI has a role to play to embed these grass-roots principles, while providing support and training in health inequalities and Health Creation to support decision-making.

NHSEI has to accept that the variation in outcomes and distribution of inequality in their geography is due to the systems they're creating. ICSs need to 'own it' – if they're not prepared to own it we won't get anywhere.

About Health Creation

Creating health must sit alongside treating ill health and prevention of illness.

Health Creation is the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced.

The 3Cs of Health Creation: Contact I Confidence I Control

Building meaningful and constructive **Contact** between people and within communities increases their **Confidence** which leads to greater **Control** over their lives and the determinants of their health. People also need an adequate income, a suitable home, engaging occupation and a meaningful future.

Having **Control** over our lives and environments is proven to enhance health and wellbeing and to help people cope well with health conditions, disability and ageing.

The Health Creation Framework: creating the conditions

Health Creation is…

…the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced.
Professionals can create the conditions for Health Creation by working as equal partners with local people and focusing on what matters to them and their communities

People need

...to be well

The 6 features of health creating practices

- Listening and responding
- Truth-telling
- Strengths-focus
- Self-organising
- Power-shifting
- Reciprocity

Health Creation is enabled through:

- **People**
- **Practices**
- **Places**
- **Policies**
- **Power-sharing**

New NHS Alliance is calling for:

1. The **adoption** of health creating practices
2. System **reforms** to support Health Creation
3. Enhanced **education** in Health Creation

Professionals can:

- **Adapt** their current practices
- **Adopt** whole new practices
- **Disrupt** by working with communities to produce whole new solutions