# Shaping The Health Creation Alliance's submission to

*A national conversation to develop the 10-Year Health Plan for NHS*

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## Q1 What does your organisation want to see included in the 10-Year Health Plan and why?

The Health Creation Alliance (THCA) wants ***the shift to a health creation model of health and care*** to be included as a fourth shift within the 10-Year Health Plan, alongside the other three shifts.

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.

### 1.1 Our rationale for wanting this fourth shift to health creation included

The Secretary of State for Health and Social Care has described the NHS as '*broken but not beaten'* while it is also the case that the health of our population is on the wrong trajectory.

The current model of health and care has not reduced the burden of preventable illness, and health inequities have grown. A range of social injustices prevent people from accessing their right to health with devastating human and financial cost of avoidable illness. Coupled with an ageing population, this is driving demand for health and care services in a way that is not possible to sustain. The proportion of public spend on the NHS has increased from 26% to 43% over the last 25 years and this does not include the uplift in the most recent Autumn 2024 Budget announcement. This is becoming disproportionate and, with constraints on revenue spend, it is at the expense of adequately funding other statutory and community services; this works against health equity. Meanwhile, profit continues to be extracted at unreasonable levels at the expense of high quality services.

Health creation needs to become business as usual across all systems to improve mental and physical health and reduce health inequity alongside efforts to treat illness and prevent ill health. This was the message in our **May 2024 Manifesto for whole system change** in which we asked for the adoption of health creation as a key goal across government along with new accountability mechanisms and a different investment strategy to make the shift to as well as some specific policy changes to remove some key barriers to health creation.

#### 1.1.1 The specific focus of this submission: health creating relationships

In this submission, the major policy changes that are required to reverse the drivers of this unsustainability across the NHS, social care, housing, VCSE sector are not the main focus

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(although they are a part of 'health creation'). We will respond to other inquiries and consultations relating to the wider determinants in due course. Also:

- THCA was an advisor to the Kings Fund research report **Making care closer to home a reality** which makes a strong case for significant policy changes to core NHS services.
- We mention a handful of policy changes that were 'asks' in our **May 2024 Manifesto** **Seven Asks of a New Government** that would make a big difference by removing barriers
- We endorse some of the IPPR's policy suggestions in their Commission for Health and Economic Prosperity Report, **Our Greatest Asset**.

In this submission, we are focusing on how the NHS needs to change in relation to people and communities, social care, housing and VCSE sector and how this might be articulated within the 10-year health plan.

Systems that adopt this relational, power-sharing approach that is core to THCA's Health Creation model, will be setting the conditions for the system to:

- Devolve agency to take the right actions and remove barrier down the hierarchy to communities and the frontline
- Be trauma-informed
- Excel in coproduction that really works [link to publication]
- Be inclusive
- Enhance equity and deliver on anti-poverty pledges
- Become anti-racist and consciously address structural discrimination of all types

The reason it supports all of these aims is that it focuses on the commonalities, the universal features of relationships that are required to build respectful, kind, trusting and strong connections that are necessary to drive constructive, purposeful change across all partners.

**A summary of outcomes from a THCA-led programme by one of our VCSE clients**

The *Winter Health – Health Creation programme* demonstrated that the Framework for Health Creation:

- can successfully be adopted and embedded into programmes to enhance their reach, impact and to improve health equity.
- supported the process which gave the VCSE organisations the 'space' to take charge, an opportunity to enhance their skills and abilities and the confidence to take greater control of their own health and wellbeing, something that was passed on to their communities.
- supported participants to build connections and relationships internally, externally with community members and other local partners, and across localities. It is through these that we are confident that Health Creation will continue to flourish.

The adoption of The Health Creation Framework was the bedrock of this programme, while the support for this provided by the Project Manager, the partnership between the VCSE organisation and The Health Creation Alliance, and the funding from the Local Care

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Organisation, enabled the VCSE participants to enhance their programmes to improve their communities health and wellbeing and to reduce health inequities.

### 1.1.2 Ten things for inclusion in the 10 Year-Health Plan

To support the shift to a health creation model, THCA wants to see **ten things** included within the 10-Year Health Plan.

- A new purpose to 'maximise health'
- An explanation of the process of health creation
- Clarity around roles in health creation and the change process
- Equity across social groups; parity between social care and NHS
- Communities recognised as (part of) the system
- Community insight fully embedded in datasets and driving action plans
- Measures of relationship quality
- Redirection of resources; invest in connection, communities and social value
- Protection of existing health creating change-work
- Health creating policies

Each of these ten asks is expanded below

## 1.2 A new purpose to maximise health

An explicit focus on maximising people's and communities' health by creating the conditions that make people well and that keep people well.

The Health Creation Alliance is asking the Government to set the conditions for a fundamental shift in focus, from over-focus on ill health treatment and unfulfilled promises about prevention and care closer to home, to a central focus on health creation.

Everyone in the UK has *'the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable'* European Social Charter (ESC) along with a range of other human social rights such as *'the right to protection against poverty and social exclusion'* and *'the right to housing'* among others.

Health creation offers a purposeful path to giving more people access to their right to the best possible health. It is about maximizing people's health; whatever state of health someone is in, for them to be able to flourish and have the best quality of life.

## 1.3 The process of health creation

An explanation of the full extent of the processes through which health is created and by which people and communities become and stay well. This must focus on the relationships, connections, spaces for connection and social processes that enhance health and wellbeing

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The notion that both mental and physical health can be created is an entirely new concept for many people who work in our health and care systems. This is not the same as preventing ill-health or simply recovering from an illness through treatment or other intervention.

Creating health requires the right conditions for everyone to maximize their health and to be able to flourish and have the best quality of life.

While health is created all the time by people and communities naturally and organically, the mechanisms by which this happens have been largely hidden from view. Perhaps because of this, there has been scant focus within public policy on how public services might support this process by play their part in creating the conditions for health to be created as a formal part of their job roles.

For this reason, we want to see a full explanation of the processes through which health is created – articulated from the community perspective, rather than (or as well as) from the service or policy perspectives which are the predominant framings in this consultation invitation – in the 10 year plan.

The Health Creation Alliance established and tested frameworks to explain this process simply, by drawing on two main sources of wisdom and insight:

- the experiences and insights of people living in communities whose health had improved over a period of time
- well known individuals and organisations from a wide range of disciplines who have been working over decades to address inequality and support people to change their and their communities' lives, including: Aaron Antonovsky, Viktor Frankl, Sir Harry Burns, Amartya Sen, The Young Foundation, Lord Nigel Crisp.

While we took the approach set out above, our frameworks also reflect the core elements of effective community development.

Core to this is the well-evidenced '3Cs'; meaningful and constructive **Connections** between people increases their **Confidence** leading over time to greater **Control** over our lives and the determinants of our health. Congenial convening **spaces** are also required to support strengthening of community connections.

A full explanation of the process and frameworks can be found in **Section three of THCA's 2024 Manifesto**

This research publication THCA produced for NHS Property Services **Creating spaces for patient and community wellbeing** digs deep to uncover what it is about spaces and the processes in which they are made available that matters most to 10 different communities in supporting wellbeing. The continued pressure on local government is, however, minimising civic spaces for connection.

Here are a handful of **examples-of-Health-Creation-in-practice**

Enabling community health creation requires not so much formal 'interventions', as a conscious and deliberate 'putting in place' the factors that cause people to be well. This includes factors that protect people from becoming unhealthy and for those whose health is already

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compromised – due to a lack of control over their lives, or to environmental or social determinants of health – it means enabling them to have agency as individuals and communities to take control, act on behalf of themselves and their community and change their circumstances.

### 1.4 Clear roles in health creation and the change process

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| Clarity about what roles different parts of the system will play in the creation and maintenance (maximisation) of our health. This must include clarity about what roles it is not appropriate to expect the NHS to play, which parts of the system will fulfil those roles, what the NHS's roles in supporting them will be and how the process of reshaping and redesigning services across silos will be led and funded. |

Health is created in and by communities and at the intersection between communities and frontline services; the role of everyone else – across all sectors and at all levels of communities, organisations, systems and policy-making – is to create the conditions for communities to create health and to remove the barriers, of which there are many.

Creating the conditions must be a collective endeavour. There are roles for everyone - the NHS, local authorities, VSCE, faith communities, housing, education, policing, fire service and many other sectors. Yet the existing structures – Primary Care Networks at Neighbourhood level – are mostly GP-dominated reinforcing silos. There are at least five government departments with that have a role; DWP, MoJ, MHCLG, DHSC, DCMS.

There is a much bigger role that communities and civil society could play in creating health, forging effective collaboration and driving change by reshaping the collective service offer locally. While the NHS has historically been constrained in several ways, VCSE organisations that understand the community development or health creation process are able to take a bigger lead in this work and also to challenge and support different parts of the NHS to innovate and change.

In fact, VCSE organisations are leading on much of this work, yet their role is almost entirely missing from national-level discourse or funding streams; at that level, the focus for 'health' continues to be the NHS. Their critical role has been completely overlooked in the recent budget announcement; it is estimated that at least 20% of charities will not be able to meet the new National Insurance increase putting them at risk of closure.

There has not yet been an honest, up front conversation about:

- what the NHS can and cannot do to create the conditions for people to be well
- whose job it is to lead on which elements of this important work
- how local partners might recognise and enable each other to play to their strengths as they negotiate roles in a collaborative environment
- how local/neighbourhood structures might be made more representative of partners, for example cross-sector Health Creation Networks involving GPs as part of the DES Contract, holding collective power at Neighbourhood as well as Place level.
- how they might be develop the awareness to step forward into leadership roles and backwards into supportive roles as appropriate

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- how national policy and funding decisions might recognise these roles and support partners locally to play them
- how devolution might support all of the above.

This conversation is badly needed – at national as well as local levels. It must be held with communities, local authorities, VCSE and other local partners – not just in NHS circles. For the last few years local partners have muddled through and this has led to a good deal of frustration, much of which could have been avoided. For example:

- Some clinicians have believed they are required to solve people's social problems when their main role may be much smaller and more specific in support of others who are doing this work.
- Hospital-to-home schemes that support people to settle in their homes after a hospital stay have often been unsupported by acute trusts who are instead focused on patient flows and specific aspects of Urgent and Emergency Care.
- Many community groups and VCSFE have felt misunderstood, wrong-footed and that their efforts to create health have often been thwarted by ignorance, unfavorable power dynamics or rigid conventions including funding/commissioning conventions.
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### 1.5 Equity across social groups; parity between social care and NHS

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| Better targeting of the right resources to disadvantages places and cohorts. An end to social care being the poor relation in terms of policy and funding. |

***Equity***

Various funding formulas and competitive bidding processes have resulted in too little money flowing into disadvantaged places or groups. Some pioneering ICSs are now changing how they use formulas (such as Carr-Hill) to direct more funding to those places that experience higher levels of social injustice (of which unfair distribution of resources is just one. We want to see a wholesale review of funding formulas in the 10 year plan.

Section two of THCA's Manifesto sets out the main 'social injustices' that are key causes of preventable illness and health inequity.

Core20PLUS5 has helped to focus minds on how systems might work differently with residents living in Core20 neighbourhoods and with health inclusion groups. This is an important element of tackling health inequalities; THCA would like to see the Core20PLUS part of this continue with more flexibility than is allowed by the five clinical priorities, to allow for systems to attend to community priorities.

***Parity***

High quality social care is absolutely essential for many people of all ages to live well every day, not just to expedite hospital discharge of older people to relieve pressure on the health system.

Not fixing social care funding or developing it into the dynamic and health creating service that it could be is a conscious choice about Governments' priorities. The £600m additional funding in the latest budget will not even pay for the uplift in the minimum wage plus employers national

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insurance for care workers. And many people who draw on care are not getting the opportunities to succeed in building community based 'health creating' support, partly due to a lack of suitable community venues.

At least three things are required:

- A recognition – by policy makers and senior healthcare professionals – of the broad purposes of the social care system, to enable people to live 'gloriously ordinary' lives fully integrated into society
- A shift from a system that gate-keeps demand and rations services to one that relates to people and, through timely conversations, provides what they require to maximise their health prevent their situation deteriorating
- To adopt Prof Dilnot's recommendations for funding social care to make the system fairer and to provide certainty for actuarial/insurance calculations

### 1.6 Communities recognised as (part of) the system (power-sharing)

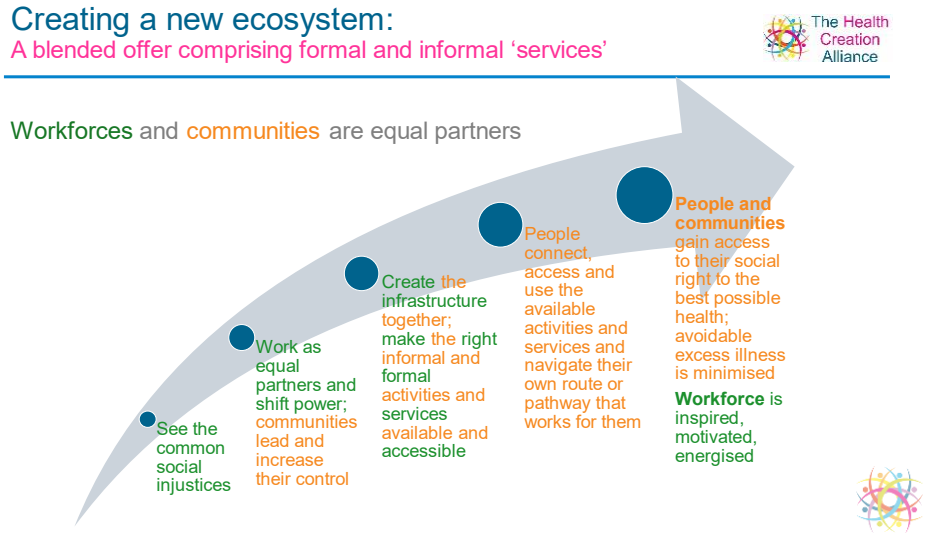
*An explicit recognition that people and communities are the principal health system and that the NHS needs to be an equal partner in all matters, given that ~80% of health is due to factors that are unconnected with treatment or healthcare,.*

The 10 year plan should be explicit about all parts of the NHS, and other local partners, 'working with' communities across activities in support of better health.

The predominant power dynamic and model characterised by 'doing to' or 'delivering services to' patients, has resulted in service designs that suit systems rather communities and has contributed to worsening health outcomes.

Ways need to be found to incentivise equal partnerships and to disincentivise behaviours that protect hierarchies and maintain the status quo. Shifting money into communities – which in any case need to be supported and funded to play roles alongside the NHS, Local Authorities, housing and other local partners – is a good way to support a power-shift.

This is how we illustrated the power-shift to a blended service offer in our Manifesto.

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Six years ago, THCA produced these materials for Greater Manchester Integrated Neighbourhood Teams, to support teams to shift/share power:

- Shifting power to our people and communities: **GM Shifting Power Narrative**
- The Power Deck: **GM Power shifting card deck**

### 1.7 Community insight fully embedded in datasets and action plans

> *Communities know a lot about what the problems are and also have ideas for solving them. There needs to be an expectation of ICSs systematically listening, sharing datasets, conversations and taking actions in partnership with communities.*

Part of the route to seeing communities as equal partners is for insights that are now regularly emerging from communities – for example, through the Core20PLUS5 Connector programme, Citizens Assemblies and Poverty Truth Commissions – to be systematically embedded alongside formal data and for it to inform the system response and commissioning decisions. This must goes beyond current coproduction practices that mostly offer only limited opportunities for communities to shape some services.

### 1.8 Measures of relationship-quality

> *For an explicit recognition that relationship quality is an indicator of health; for an expectation that all parts of the system will adopt the six features of health creating relationships – listening and responding, truth-telling, strengths-focus, self-organising, reciprocity and power-sharing – as the gold standard as a measure of system health and for measures of social capital to be adopted as a measure of community health.*

While evidence of health outcomes from specific interventions can take years to emerge, rapid measures of relationship quality offer a strong indicator of a healthy service or system.

We are proposing two types of measure of relationship-quality:

- **Measure of system health;** by assessing relationships between different parts of systems against each of the six features of health creating relationships – *listening and responding, truth-telling, strengths-focus, self-organising, reciprocity and power-sharing* – on a scale of 1-10, it is possible to gain a picture of the health of a system in identifying and solving problems together
- **Measure of community health:** in addition to using the six features (outlined above – and for which THCA has a diagnostic), it is possible to measure social capital by using ONS measures. This gives an indication of the health of a community.

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### 1.9 Redirect resources; invest in connection, communities, social value

> *For resources and funding to flow to the right parts of the system in the right proportions to maximise Social Value and change the dynamic in the relationships between local partners and communities and support emergence of a fully health creating ecosystem.*

The 10 year plan must reverse the trend for the NHS taking an ever increasing proportion of public spend by committing to redirect a much higher proportion of public resources into community settings and health creating activity.

There are many analyses showing the increase in the number of hospital consultants and specialists alongside reduced productivity.

According to the Institute for Fiscal Studies: the past-and-future-uk-health-spending – 14 May 2024, NHS expenditure has increased over the last two decades: in terms of absolute spend, relative to the size of the economy and as a share of government spending over time. The DHSC's budget has dramatically increased from a 26% share of the all-departmental total in 1998–99 to 43% in 2022–23. **Delivering health services has become a larger and larger part of what the government does.**

The UK has moved up the ranks of health spending among comparable countries, going from comfortably below the European average in the early 1990s to around the average in the mid-2000s and slightly above average from the late 2000s onwards. Since the pandemic, UK health spending has surged further up the (European) ranks, standing behind only France and Germany in 2022.

**The size of the NHS means that any increases in health spending will force difficult fiscal trade-offs elsewhere.** Under the government's current plans for public service spending, delivering the NHS workforce plan in England implies flat real-terms budgets for all other government departments. Taking into account other spending commitments on childcare, defence, and elsewhere implies large real-term cuts to remaining departments; avoiding them would require a higher overall spending envelope, which, in the absence of a marked improvement in economic growth, would need to be funded by some combination of increased borrowing or higher taxes.

This disproportionate investment in treating ill health compared to investment in the factors that keep people well in society is a poor investment and that it will not solve the NHS's problems. The trend won't change without direct intervention to redirect resources and invest differently.

The 10 year plan must shift investment:

1. to enhance the connections between community members, between communities and system partners and between system partners
2. to support skilled facilitators to undertake this important work
3. to develop leadership skills that empower teams to act on what they have heard from communities
4. to resource non-NHS organisations, communities and workforces that play significant roles in reshaping services, systems and in creating health.

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5. to support community-facing NHS roles in community settings (not just in NHS settings)
6. by raising the bar on Social Value requirements in contractual services, ensuring that all service providers to statutory sectors have a generous 'community investment' offer – and are unable to extract unreasonable levels of profit that compromise service quality

THCA has been able to measure how well an organisation or system is doing at creating health for some years. These measures need to be developed further and adopted as formal measures that support better commissioning and funding of health creating activity and that hold systems to account for making the shift.

### 1.10 Protect of existing health creating change-work

| For a commitment to support the great work that some Integrated Care Systems have been driving forward to reorient their systems to creating health model. For a number of reasons this work is at risk. It is in urgent need of stabilising. |
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Despite minimal national direction some ICSs have been innovating and driving health creating approaches over the last few years. Where this is the case, they have often been working with and learning from organisations outside the NHS.

THCA has seen examples of NHS staff having permission to spend their time working closely with VCSE and Community Connectors to support bids for funding and to help reshape services. These relationships are enabling crucial two-way communication, providing valuable insights and supporting system validity for community connecting as a driver of change.

The best of this work is quite sophisticated, yet it is being completely overlooked in terms of its relevance to changing the way the UK drives health or how the NHS works. Senior decision-makers and finance directors are typically too far removed from the activity 'on the ground' to understand how it works and as a result the programmes are at risk.

The 10 year plan must support this important work so that it can continue to develop, grow and be enhanced further. It can do this by including and taking forward the actions 1-8 above.

### 1.11 Health creating policies

| For a commitment to adopt public policies informed by the voices of people with experience of poverty, trauma and discrimination and that (1) help to create the conditions for health creation at the same time as (2) remove barriers to health creation. |
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THCA looks principally through the community lens at the problem of avoidable ill health and health inequity – to see the problems and solutions as experienced by individuals and communities living in poverty, with trauma and experiencing discrimination.

However, we do recognise that some of the negative influences on people's and communities' lives that create barriers to their ability to create health can and should be changed through national policy.

When considering which policies will support and remove barriers to health creation, we support Poverty Truth Commissions' in their ambitions for people with lived experience of poverty to be fully a part of decision-making. Their starting point is that *'Nothing about us,*

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*without us, is for us'* and they contend that lasting social change only happens when those who experience the struggle participate in generating that change.

This must apply to the national policy level as well as system, place and neighbourhood level. Our national structures for policy decision-making must evolve so that the voice of people with the deepest experience of poverty, trauma and discrimination is explicitly sought and embedded into policy-shaping processes across all aspects of Government.

THCA has recently completed a project for the Voices for Tenants Group, to support emergence of an unmediated 'National Tenant Voice' to influence policy on housing matters. This will be published shortly.

**Q2: What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?**

We have proposed many enablers to moving from hospitals to communities within our response to Q1.

A significant challenge is the many ways the phrase 'from hospitals to communities' and 'care closer to home' are interpreted. Those who hold the most power with decision-makers tend more towards interpretations that support the status quo rather than interpretations that make the required shift happen.

For example, for some NHS employees, 'community' is often used interchangeably with 'Community Trusts'. Outside the NHS it can means people living within the same locality, sharing an identity such as an ethnic group, or a common interest.

The above statement is also often taken to mean moving treatments into new healthcare settings outside hospitals, rather like the 'polyclinics' that Lord Ara Darzi proposed in the early 2000s. Housing organisations, VCSE and many Deepend GPs who work directly with communities will understand the requirement for a much more fundamental reshape the way services are delivered to meet the needs of those communities.

This can cause both confusion and disappointment when the resulting policy and system changes are too insignificant to meet the scale of the challenge.

THCA's preference is for government to cease using this phrase and instead be more specific that what is required, for example;

- A shift to creating health, not just treating and preventing ill health
- Better health of communities in community settings
- Front end health – such as screening and some treatments – available in community-led, community-owned settings such as existing community centres
- Systematic approaches to addressing the social determinants, for example, to improve poor housing
- Redesigned services, shaped by local people

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Notwithstanding the above points, the Kings Fund '*Making Care Closer to Home a Reality'* report does identify some key barriers internal to the NHS that also need to be overcome for this shift to take place.

### Q3: What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

[To be completed]

### Q4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

We have proposed many enablers to shifting from an illness to a prevention (and health creating) model within our response to Q1.

Again, language used differently by different sectors can be a significant challenge.

There are at least three official definitions of 'prevention' understood by the NHS – primary, secondary and tertiary prevention; all three are important for NHS teams. However, while health creation could be seen as a form of primary prevention, this description does not go sufficiently far to describe the social processes involved in creating health nor the nature of the protective factors that it provides. Descriptions speak of 'interventions' but there is no mention of 'creating conditions' which requires a different approach and skill set.

Neither does the word 'prevention' convey the idea that poor health could be reversed; rather it more often constrains people from taking decisions over their own lives; this exacerbates problems by taking control away from people.

Some Recovery Colleges and Mental Health organisations will testify this is achieved through health creation that gives control and this needs to be recognized, built into systems as standard and invested in.

For some people the word 'health' is synonymous with 'healthcare' or 'the NHS' rather than population health, community health or creating health.

### Q5: Please specific policy ideas for change.

Our main 'idea' is the imperative to formally shifting to a community health creation model that is shaped by communities, as a cross-sector endeavour, including the formal health service (the NHS) and the informal health service (other local partners). The rationale for this is set out in Question 1.

We also have many ideas for specific policy changes to support that; the ones listed below are a small sample. Please get in touch if you would like to discuss these or others further, or any of the other ideas in this submission.

- **Shift to a health creation model, embedding the approach as a fourth shift that is required and core to our health system**; along with the notion that is should be normal for

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people to be healthy. It is our human social right but people are ill because they do not have sufficient agency over their own lives and environments and the burden of avoidable illness is making the NHS unsustainable. This can only be reversed through adopting health creation wholesale.

- **An independent body** (not part of electoral cycles of parliament) whose job it is to drive forward work to develop fully health creating systems so that health creation no longer falls through the cracks. This body would:
    - work with the learning from pioneering ICSs and across a range of sectors
    - support all systems to take steps towards become fully health creating systems
    - inform Government of the shifts and policy changes required to enable emergency of fully health creating systems

- **A right for everyone and every community to be helped to construct their own 'social pathway' to good health**. This could be achieved through conversations with people and communities through which they determine and communicate the things they need to be in control of their own lives and environments and that will enable them to access the things they need when they need them. The role of services is to help them to connect with their solutions in a timely way.

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