NNHSA Submission to

DHSC Prevention Green Paper

The paper asks many questions. We have identified 8 of them that are particularly relevant to our organisation mission and have focused on those.

Q: Which health and social care policies should be reviewed to improve the health of: people living in poorer communities, or excluded groups?

In poor communities and excluded groups, the biggest drivers of poor health are disconnectedness, hopelessness, despair. To be well, people need sufficient of the '3Cs of Health Creation'; Control over the circumstances of their lives, meaningful and constructive Contact with other people, Confidence to take action with others to make improvements. The route to improving their health is to support them to increase their levels of Control, Contact and Confidence.

There are too many policies in need of review to mention here. Limiting funding to programmes that have a 'traditional' evidence base, eg. smoking cessation, favours a 'one size fits all' approach but these programmes miss underserved communities that suffer multiple disadvantages; meanwhile the real answers are continually overlooked.

An NNHSA project with Leeds Hepatitis C Sex Workers showed a seven-fold increase in the number of women cured of hepatitis C over 12 months (from 1 in previous 12 months to 7 now). This was achieved by employing the '5 features of health creating practices' with local partners (See: https://www.nhsalliance.org/health-creation/). A fundamentally different way of thinking about the role of government policy in enabling workforces to become equipped with skills in Health Creation is needed.

Q: How else can we help people reach and stay at a healthier weight? (Ch2)

The multiple causes of obesity include genetics, social determinants such as poverty, the economics of advertising junk food. Poor people often say they know they should eat more healthily but they can't afford to. This is compounded by 'fresh food deserts' and fast food outlets that communities have little control over. Some solutions lie in addressing these matters, for example through community food-growing projects, clubs like Holiday Kitchen https://accordgroup.org.uk/about/projects-and-partnerships (scroll down) which focuses on connecting, learning and having fun as well as providing healthy meals through school holidays).

Achieving/maintaining a healthy weight is more likely when people are doing an activity they enjoy with others they feel a connection with; weight-loss becomes a secondary matter rather than the main focus. The Health Creation framework is a helpful guide. The inspiration comes in many forms:

- For Jen Blackwell and Becky Rich of @DanceSyndrome, dancing is their passion and their testimony is that leading this dance company has led to weight loss because they're doing what they enjoy
- Amelia Bilson, who had gained weight when she went through post-natal depression, eventually lost weight as she became more connected and involved in her local community group, Middleport Matters.

Q: Can you give any examples of any local schemes that help people to do more strength and balance exercises?

In Limehurst, Oldham, one resident called Kevin was interested in fitness and was inspired to establish a gym and nutrition advice in premises at the heart of his community, supported by his landlord Regenda. When members of the community saw the difference it made to him and his wife (who had suffered serious depression) they started attending the gym and local doctors started to refer people to it.

This demonstrates the potential for community members to drive health outcomes with other residents, in their localities, with the accompanying improvement in confidence.

Q: There are many factors affecting people's mental health. How can we support the things that are good for mental health and prevent the things that are bad for mental health, in addition to the mental health actions in the green paper? (Ch2)

New NHS Alliance 'Give Us a Voice' experts by experience (of mental health) cited:

- Having to repeat our story over and over
- No choice in statutory workers allocated to our case
- Multiple workers ie family support, social workers, substance misuse workers who have different opinions about our issues yet do not give a voice or 'stand up' for the rights of the service user
- Poor housing
- Lack of employment opportunities
- Insufficient money to cover basic costs – rents, utility's bills, food prices have increased while employment income has stagnated.

Some solutions

- Making metal health education compulsory in schools - maintaining good mental health is a life skill and younger generations should be educated in how to do it
- Active promotion and funding of joined up multi-disciplinary services (eg. versions of Troubled Families Initiative but including single people) so only have to tell their story once and receive a consistent approach. Peterborough has a good approach.
- Availability of advocacy.

Support for peer-led recovery, which can be very powerful, should be increased. For example Telford After Care Team (TACT) http://www.tacteam.org.uk/ a well-established community/peer-led 'recovery from addiction' organisation. Stockport Homes Homeless Hospital to Home Scheme offers another model of 'peer mentoring'.

Q: Have you got examples or ideas for services or advice that could be delivered by community pharmacies to promote health? (Ch2)

The Building the Community-Pharmacy Partnership (BCPP) Programme https://www.cdhn.org/bcpp brings communities and pharmacists together across Northern Ireland to address root causes of poor health: mental health, housing issues, low educational attainment, poverty, debt (much more than 'lifestyle decisions').

Pharmacists are supported (financially) to engage with the local community. The trust, relationships and insights they gain increases awareness of local/regional support organisations, confidence signposting and enhanced communication.

"It has been fantastic to interact with the community in a way that removes the 'white coat' and provides an opportunity to build great community relationships." Eamon O'Donnell, Pharmacist, Boots

"It was amazing what the men got out of the initial programme in such a short space of time some saying they had a new lease of life. As a direct result, these men are now approaching pharmacists with their health queries and feel empowered to take responsibility for their health." Anita Gribbin, Pharmacist, Gribbin's Pharmacy

In Eccles, a story – co-written by children, parents, clinicians – was read out in school assembly encouraging children to steer family members to the ´chemist´ rather than their GP. In six months, pharmacy consultations rose from ~250 to >350 per month and prescribing of paediatric paracetamol and ibuprofen had declined sharply.

There are examples of pharmacy/housing collaborations where pharmacies are accommodated at the heart of disadvantaged communities in 'one stop shop' community health and wellbeing hubs. Examples include: May Local Healthy Living Centre in Liverpool https://www.onward.co.uk/may-logan/, and Limelight in Old Trafford https://www.limelightoldtrafford.co.uk/

Q: What could the government do to help people live more healthily: in homes and neighbourhoods, when going somewhere, in workplaces, in communities? (Ch3)

- Create new outcomes measures that focus on what matters to people.

- Develop incentives and levers that support the practice and development of Health Creation. For example, through the GP contract, expectations around transformation of patient participation groups (Eg. Alvanley Practice, Stockport).
- Give people more control, contact and confidence in personal care and support planning, with practitioners having more flexibility to work with people to focus on what's impacting on them.
- More support for workforce learning/development in Health Creation – through ICSs and Primary Care Networks, for example.
- Work with experienced organisations (like NNHSA) to develop:
    - Health Creation modules into undergraduate and post-graduate education programmes – for doctors, nurses, pharmacists, allied health professionals, social workers, public health, housing professionals.
    - good practice guidance for Health Creating practice in different settings.
- Invest in 'community health creators': people with a track record in successful asset-based community development.
- Support training and peer mentorship to enable 'community health creators' to be effective in their own communities and others – spreading community-to-community know-how.
- Develop an enabling framework, culture and approach to risk across the health and care systems that enables innovation in Health Creation.
- Provide funding to further strengthen the evidence base for Health Creation.

Q: What government policies (outside of health and social care) do you think have the biggest impact on people's mental and physical health? Please describe a top 3

1. Unfreeze and restore Local Housing Allowance (LHA) to pre-2016 levels so people relying on housing benefit can access at least 30% of available accommodation locally. In some areas up to 50% of homelessness is caused by households no longer being able to afford their private rents. Crisis has evidence of net savings to government and reduced human misery if this were actioned. Make it possible for people to live on benefits – currently there are too many gaps making it impossible in some instances for people to afford rent, food and fuel bills. This shouldn't be possible. Benefit advisors know where the cracks are and have ideas about how best to reform.
2. Introduce a government-sponsored loans fund for home-owners to borrow to improve their homes to a basic minimum standard (especially warmth). It could be means-tested with interest rates ranging from nil to bank rates depending on circumstances to be repaid when the property is sold. The best councils are offering versions of this; it needs to be scaled into a nationally supported scheme.

3. Fully implement Health Creation and community strengthening approaches across local authorities and other local partners and 'health-proof' all policies, across all government departments.

Q: How can we make better use of existing assets – across both the public and private sectors – to promote the prevention agenda?

Assets fall into at least three linked categories:

- human assets (eg. service users, citizens, patients, communities),
- physical assets (eg. land, premises, green space)
- the workforce – from frontline to senior executive, the workforce can help or hinder prevention and health creation.

When it comes to human assets it's important **not** to see this merely as 'making better use of assets'. Statutory services need to foster profound respect for the knowledge and skills held by people and communities and community-based organisations and be prepared to work as equal partners in co-creating and co-delivering solutions to local problems with them. Some physical assets can be useful to communities but asset transfer must not be a route for statutory services to offload the poorest assets.

A system of investment in both community organisations, networks and making useful physical assets available (including health estate) is badly needed.

New NHS Alliance would like to see all frontline staff across all sectors equipped with skills in Health Creation so that they can be an asset, helping to create the conditions for people to increase the levels of Control, Contact and Confidence – the 3 Cs of Health Creation that people need to be and stay well: http://www.nationalhealthexecutive.com/Comment/developing-a-wellness-workforce

Q: What more can we do to help local authorities and NHS bodies work well together (Ch3)

Health care accounts for approximately 10% of a population's health: https://www.health.org.uk/blogs/health-care-only-accounts-for-10-of-a-population's-health

A recognised 'Social Model of Health' must emerge to support the other 90% . This needs to be understood as everyone's job – all sectors and communities themselves – and it needs to have Health Creation at its core: See https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31801-3.pdf and https://www.nhsalliance.org/health-creation/

The most important short term action government can take is to **increase funding available to local authorities that are working collaboratively across sectors (including the NHS) and with communities to solve local problems** on the proviso that:

(1) LAs and NHS (CCGs) are routinely commissioning jointly for prevention and health creation
(2) LAs are collaborating effectively with schools, housing, transport, economic development and NHS partners
(3) communities influence what is commissioned eg. through co-design process, community-led advisory panel, community development.
(4) significant funds are devolved for community-led activity

Putting more money in the hands of democratically accountable health bodies (LAs) that ***understand the need to be accountable to communities for population health*** will make the LA sector a more attractive partner to the NHS. A programme of peer-sharing in Health Creation and collaborative working is also needed to accelerate progress of those that are less good.

What other areas (in addition to those set out in this green paper) would you like future government policy on prevention to cover?

Support a recognised 'Social Model of Health' to emerge, with incentives to work collaboratively between local partners and with communities and with the capability, capacity and authority to deal with the myriad social causes of ill health, as experienced by people and communities.

New NHS Alliance contact:

Merron Simpson, Chief Executive: merron@newrealities.co.uk