Major conditions strategy call for evidence, Department of Health and Social Care

People's Health Trust response

Context

In January the UK government announced that it had dropped its plan to publish a health disparities white paper, despite repeated public commitments and widespread support from organisations working to address health inequalities. The government decided to combine the white paper with the mental health plan and other commitments on cancer and dementia into the "major conditions strategy". We wrote at the time that we did not believe this was the right decision and that a cross-government strategy on health inequalities was urgently needed.

In May, the government announced a call for evidence for the major conditions strategy seeking views on how to prevent, diagnose, treat and manage the six groups of health conditions, including: cancers, cardiovascular disease, chronic respiratory diseases, dementia, mental ill health and musculoskeletal disorders.

Our response

How can we support people to tackle risk factors?

There is extensive evidence demonstrating that socio-economic disadvantage and other forms of marginalisation are a major driver of poor health (Clark, AM., et al. 2009) (Woods LM, et al. 2005). Since the WHO's Commission on Social Determinants of Health and the first Marmot Review (2010 and 2020), there is widespread recognition that people's health and wellbeing is shaped by the environment and conditions of our lives (Marmot, M. 2010) (WHO, 2008). According to the World Health Organisation, these social and economic determinants are estimated to drive between 30 and 55 per cent of health. These factors include poor housing, poor quality, low paid jobs and low income, poor air quality and access to green/blue space, and stronger social connections. Discrimination is also a social determinant of health, with evidence suggesting that those with experience of racial discrimination have increased stress levels leading to higher allostatic loads resulting in poorer health (Hackett, R. et al, 2020). These factors must be addressed for population level prevention to be successful.

Measures targeting individual behaviour change to reduce the risk of developing the major conditions, such as maintaining healthy weight and exercise, stopping smoking, and reducing alcohol intake, are less successful when taken in isolation from the social, economic, and environmental conditions of communities. Lifestyle interventions are less successful with people on lower incomes because changing diets and exercising

more requires resources that many people do not have access to (Lakerveld, J, et al. 2008). Requesting smoking cessation and alcohol reduction fails to recognise that these are strategies people put in place to cope with complex social and economic burdens (Hiscock, R, et al. 2012). It is only by addressing these societal burdens that we can begin to address the impact on health. As Professor Sir Michael Marmot wrote, "why treat people and send them back to the conditions that made them sick?" (Marmot M. 2015).

Focus from Government on the social and economic determinants of health alongside personal responsibility messaging will address the root causes of intractable diseases which blight many lives.

The near 20-year gap in life expectancy between those from the least and most disadvantaged in England and the flat-lining of life expectancy of the nation (and declining for working class women) requires a cross-government approach. We recommend a 'Health in All Policies' approach so that policy areas related to social determinants such as housing, jobs, income, local environments become effective prevention strategies all contributing to the goal of improving health and reducing pressures on the NHS (Marmot, M. 2010). This approach should use national and local levers to improve factors that directly influence health such as poor housing, poor quality, low paid jobs and low income, discrimination, poor air quality and access to green/blue space, and stronger social connections. This cross-government strategy is supported by the Inequalities in Health Alliance, a coalition of over 200 organisations convened by the Royal College of Physicians who believe tackling social determinants of health is essential for improving health and reducing health inequalities.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

We funded locally commissioned community-led research in a neighbourhood that experienced the worst impacts of the Covid-19 pandemic in West Midlands, which further entrenched existing health inequalities. A survey of local residents of largely South East Asian descent found a significant disconnect between local people and the local health services. The report identified a number of recommendations that we believe are relevant to all areas looking to build person-centred care and joined-up services. These were:

1. Structural change – Local health structures need to have a mechanism of communication and accountability to local residents built in. The new ICS structure and the role of voluntary and community sector (VCS) representation

should provide an important mechanism of achieving this. It will be important to evaluate how this is operating to ensure local communities have the opportunity to share expertise on how health and social care teams can deliver community-centred care and more joined-up services.

2. Availability of Data - The report recommendation is for NHS policy as outlined in the CORE20PLUS5 to be applied to the neighbourhood/ward. This requires the availability of accurate data on residential health needs, which at present is not available in all neighbourhoods where there is an overlap of services. Other forms of data, such as translation and interpretation uptake and availability, can also be used to review the suitability and accessibility of services.
3. Communication – In this neighbourhood, a Health Commissioners' forum was created to provide a valuable opportunity for local residents and stakeholders to engage directly with NHS staff and senior personnel. This process of engagement was very useful for all the participants as it opened a communication channel and a way for local voices to be expressed. Examples such as these should be tested and evaluated to provide further opportunities for local communities to feedback on the suitability and accessibility of health services.

How can we better support those with mental ill health?

People's Health Trust provided a comprehensive response as part of the 2022 consultation on the 10-year plan for mental health and wellbeing for England. We conducted workshops with our funded partners who are grassroots voluntary and community sector organisations working in communities experiencing disadvantage. Our full response is here.

Key points included:

- Waiting times mean that mental health services were not accessible or available to many communities. Many felt services were impossible to access until the point of crisis when intervention may only have limited benefits.

- Marginalised groups and men were less likely to attend mental health services if they had to wait due to a lack of trust in the system, which can then lead to problems worsening. Men can take longer to engage overall, to build trust with and to open-up around mental health issues and this needs to be considered by the mental health approaches to support men's mental health effectively.

- Many of the perceived root causes of mental ill health were drawn from everyday challenges related to social determinants of health – e.g. quality and security of housing; lack of social connections and control over life; or having sufficient income from good work to meet basic needs. For many people and

their families, not being able to meet these needs was a key stressor in relation to mental health.

- For many minoritised ethnic communities, including refugees and people seeking asylum, racism and other forms of direct and indirect discrimination had worsened mental health and compounded the effects of other stressors they experienced.

- Informal routes to mental health support and activity-based sessions that take the focus away from mental health are an important means of engaging men specifically, but also some minoritised ethnic groups. However, referrals into the voluntary sector are often made without additional funding and capacity building support which is unsustainable.

- Community sector groups led by trusted community leaders were identified as having a critical role in providing informal and direct mental health support. Community organisations are small and local and can offer tailored and more nuanced support to their community. This local intelligence attuned to diverse needs can be transformative in supporting health within neighbourhoods through the successful implementation of ICS structures. However, responding to multiple needs and complex issues is an immense burden and these groups should receive additional resources and support to do this work effectively.

- Mental health training is required at scale to support community leaders –both to work even more effectively and to protect against the real threat of burnout.

- DHSC should adopt the Marmot Indicators at the ICS level across the country in order to create better foundations for the prevention of mental ill health through a focus on social determinants.

- There is also a role for mindfulness initiatives which are shown to reduce stress, help to manage long-term conditions and positively impact mental health. A recent briefing by The Mindfulness Initiative has a set of recommendations for policymakers on how mindfulness can support addressing poor mental health.

Consultation response published 27 June 2023.