# The Association of Directors of Public Health Consultation Response

# Major Conditions Strategy

## Objectives and Scope

The ‘Major conditions strategy: call for evidence’ was published by the Department of Health and Social Care. The consultation seeks views and ideas on how to prevent, diagnose, treat and manage the six major groups of health conditions that most affect the population in England. These are:

- cancers
- cardiovascular disease (CVD), including stroke and diabetes
- chronic respiratory diseases (CRD)
- dementia
- mental ill health
- musculoskeletal disorders (MSK)

The views and ideas gathered will inform the priorities and actions in the major conditions strategy.

### About the Association of Directors of Public Health (ADPH)

ADPH is the representative body for Directors of Public Health (DsPH), and is a collaborative organisation, working in partnership with others to strengthen the voice for public health, with a heritage which dates back over 160 years. ADPH works closely with a range of Government departments, including UKHSA and OHID as well as the four CMOs, NHS, devolved administrations, local authorities (LAs) and national organisations across all sectors to minimise the use of resources as well as maximise our voice.

ADPH aims to improve and protect the health of the population by:

- Representing the views of DsPH on public health policy.
- Advising on public health policy and legislation at a local, regional, national and international level.
- Providing a support network for DsPH to share ideas and good practice.
- Identifying and providing professional development opportunities for DsPH.

# ADPH Position

## Response to Individual Questions

### Cardiovascular Disease

Q1: In your opinion, which of these areas would you like to see prioritised for CVD?

- Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention).
- Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention).
- Getting more people diagnosed quicker.

Q2: How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)?

Poor detection and management of CVD is worst among working aged men. Therefore, campaigns and programmes of work could be delivered through employers.

National guidance should be provided on the use of Point of Care Testing (POCT) for managing cholesterol. There should be a review of the NICE guidance which prioritises ambulatory blood pressure monitoring (ABPM) for diagnosis. There should also be strengthened guidance on the use of home blood pressure testing, which has become increasingly popular.

In addition, more clarity is needed on the detection of atrial fibrillation (AF). The current UK screening guidance states that screening for AF is not recommended due to the harm that anticoagulation may cause. However, better CVD case finding could lead to improved health outcomes, especially when increased case-finding in hypertension may also lead to detection of AF.

To support patients diagnosed with CVD, better education should be provided to encourage self-management. Group sessions can for example be provided in different languages.

### Chronic respiratory diseases

Q3: In your opinion, which of these areas would you like to see prioritised for CRD? (Select up to three)

- Preventing the onset of CRDs through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention).
- Stopping or delaying the progression of CRDs through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention).
- Getting more people diagnosed quicker.

### Dementia

Q4: In your opinion, which of these areas would you like to see prioritised for dementia? (Select up to three)

- Preventing the onset of CVD through population-wide action on risk factors and wider influences

on health (sometimes referred to as primary prevention).
- Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention).
- Getting more people diagnosed quicker.

## Musculoskeletal conditions

Q5: In your opinion, which of these areas would you like to see prioritised for MSK? (Select up to three)

- Preventing the onset of MSK through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention).
- Stopping or delaying the progression of MSK through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention).
- Improving non-urgent and long-term treatment and care to support the management of MSK.

## Tackling the risk factors for ill health

Q6: Do you have any suggestions on how we can support people to tackle these risk factors? [Yes/ No]

Yes.

Q7: How can we support people to tackle these risk factors?

We are disappointed that although primary prevention has been listed in the consultation as one of priority areas, we are limited to 500 words to discuss primary prevention under this question. This is contrary to other areas (eg secondary prevention and treatment) where elaboration on each of the major conditions is allowed. We urge the Government to shift the focus from treatment to prevention to address the root causes of poor health.

Prevention is not only about medical interventions (secondary and tertiary) and individuals modifying their behaviour. It is not only 'social prescribing', harm reduction, or what local public health teams do. Whilst NHS health services play an important role, it is the social and commercial determinants of health that truly define our health and wellbeing throughout the life course.

Years of funding cuts to public health have resulted in greater economic inactivity, and increased burden on our health and social care systems.[1] More investment should be dedicated to primary prevention which is three to four times more effective in reducing mortality than the NHS.

The following measures should be adopted to create healthier environments:

### Healthy weight

A healthy food environment can be created by utilising Health Impact Assessment (HIA) and engaging local communities. It is also important to restrict marketing of food high in fat, salt and sugar (HFSS) to children. The proposed 21:00 watershed should be extended to all audio-visual advertising, including radio, cinema and digital out of home adverts. Further action is also needed on HFSS foods labelling that includes the out of homes sector and to prevent legislation gaps that allow schools to provide innutritious foods to their pupils.[2] Retailers should be incentivised to keep unhealthy snacks out of checkouts and queuing areas in shops.

### Tobacco

The Government should introduce a new Tobacco Control plan to tackle tobacco use, increase the age of tobacco sale from 18 to 21, and revise the tobacco tax escalator so that it is 2% above average weekly earnings rather than retail price index (RPI). The Government should also introduce a national licensing scheme to eliminate illicit tobacco trade, and to end selling of tobacco products to minors. There should be stronger regulations to limit e-cigarette sale to underaged children.

### Alcohol

The Government should introduce a strategy to reduce alcohol harm. There should be a body independent from the alcohol industry to regulate alcohol, devise measures on harm reduction and educate the public. The Government should also implement a minimum price of 65p per unit of alcohol and reintroduce the tax escalator on alcohol at 2% per annum ahead of inflation. The Government should reduce children's exposure to alcohol advertising through a ban to cinema, outdoor and bus advertising; the introduction of a TV watershed; and restricting online exposure and alcohol sponsorship.

## Supporting those with conditions

Q8: Do you have any suggestions on how we can better support local areas to diagnose more people at an earlier stage? [Yes/No]

Yes.

Q9: How can we better support local areas to diagnose more people at an earlier stage?

### Suggestions for multiple conditions

Without proper planning, universal action to improve health (eg screening) can widen health inequalities, as vulnerable groups are less likely to engage with health services.[3] For example, people may have difficulty navigating the system or have had past experiences of being turned away or being badly treated. There is a need to invest in community development approaches and learn from the effort to reduce inequality in vaccination rates during Covid-19.

We welcome the Strategy's focus on reducing health inequalities. We also welcome the Strategy's commitment to work towards a model of 'preserving good health' and to build a better system for serving patients with complex needs. There is a need for a shift in the NHS policy towards generalist care to treat multi-morbidity which has implications on resources within the NHS. This requires efforts from not only the hospitals, but also local public health teams and other partners within the system. To achieve whole-person care, a major shift in culture is also required, which can be difficult. It is important to build on good practice and ensure there is collaboration within the system.

While the Strategy is well intended, we are concerned that the focus on creating real equity in health could be lost because of the decision not to publish the Health Disparities White Paper. Narrowing the field down to six major conditions and focusing on detection and treatment is inadequate in improving health and addressing health inequalities. Health is not just the absence of disease and mental health conditions, and the narrative of personal responsibility is not the answer. Health is about whole-person wellbeing that is influenced by a range of other factors in the environment. Therefore, a whole system, cross-government, life course approach that goes beyond the NHS is required to address the underlying social and commercial

determinants of health to improve health and prevent health conditions from developing in the first place. In addition to adults, children and young people should also be invested in. Policy making should consider the needs and voices of different population groups to avoid widening existing inequalities. Voluntary and community (VCS) sectors should also be involved in promoting population health and wellbeing. Local and national governments should learn from the Welsh Future Generations Act and the transition to 'Wellbeing Economy' in Scotland.

At a place level, LAs, Health and Wellbeing Boards (HWBs) and ICSs play an important role to improve population health. It is crucial therefore that they are given the necessary tools and policy levers to:

- Understand where the inequalities exist and ensure plans reflect how these will be addressed.
- Provide an approach that is holistic and person centred with actions to benefit all but with a scale and intensity reflecting the level of disadvantage.
- Tackle the social determinants of health, save money, and create value.

## Suggestions for CVD

A whole system approach to secondary prevention is needed with localised pathways that take account of inequalities and population needs. Pathways for CVD prevention should include the work on tobacco, nutrition, weight, and alcohol as well as the clinical case finding and management. There are some examples at the local level of Healthy Hubs/Healthy Living Hubs in communities and acute trusts. It is crucial to explore how these approaches may be incentivised via the national acute trusts and the contract outcomes of mental health trusts. These approaches can be integrated into existing priorities such as elective recovery (eg focusing on higher risk individuals from more deprived areas with complex care needs who would be waiting longer).

CVD secondary prevention should model the US's Million Hearts Initiative.[4] There have been plenty of programmes in the UK that follow its example. The Bradford Healthy Heart (now West Yorkshire) particularly is well developed. It focuses on combined risk factors (smoking, lipid and hypertension) and shifting population means instead of focusing only on individuals with high risk. It also involves systematic application of quality improvement strategies to the whole population with smart use of data.

It is crucial to adopt a population wide approach to quality improvement in CVD prevention around high impact CVD markers. A quality improvement approach could be used to establish an Achievable Benchmarks of Care (ABCs) for improving care.[5] This requires data, capacity and the use of a quality improvement method. However, primary care capacity is a real issue. Restarting NHS health checks is a struggle.

There are currently numerous pots of investment for prevention and to support NHS Long Term Plan and implementation coming down the stream via OHID, NHSE and other channels. It would be useful to have some strategic co-ordination on pulling those resources together into more meaningful and sustainable funding streams. It is also important to ensure that DsPH are included in the communication of funding streams relevant to prevention and inequalities from NHSE. Regional DsPH can co-ordinate that communication.

Training, education and sharing of best practice are important as well. It is crucial to embed prevention and population health education into undergraduate and postgraduate training as well as job inductions across various specialists.

### Suggestions for dementia

Diagnosis is often delayed because of the false preconception that dementia is a natural consequence of ageing or because of an individual's reluctance to seek help about their memory problems. Fewer than 50% of patients with dementia have a formal diagnosis; and diagnosis often occurs when it is too late for patients to make their own decisions about treatment.[6] It is important to raise public awareness of dementia and its early signs and to give advice on living with dementia so that people are aware of the treatments and support services available in the community. It is also crucial to reduce stigma and to build dementia-friendly communities to ensure that people with dementia feel valued and supported in the community.[7]

Q10: Do you have any suggestions on how we can better support and provide treatment for people after a diagnosis? [Yes/No]

Yes.

Q11: How can we better support and provide treatment for people after a diagnosis?

You might consider suggestions that help people to manage and live well with their conditions, with support from both medical and non-medical settings.

### Suggestions for multiple conditions

Primary care provides general care for people from birth to death. However, primary care is under constant strain. Support needs to be broader than the clinical aspects. Welfare support, counselling and employment support are important. Supporting working parents and people with caring responsibilities should also be a priority. Adequate paid parental leave has benefits to parents, children and wider society and the economy.

A whole system approach is vital to support people with a diagnosis. This approach should include a focus on good and affordable housing, safe and healthy environments, active and accessible transport, good education, supported families, healthy relationships, empowered individuals and supportive social networks.

People with long term illness and poor mental health can become trapped in ‘low pay/no pay’ cycles of temporary, usually poor, employment.[8] [9] [10] Stigma and discrimination remain barriers to people with disabilities.[11] Support should be provided through temporary job modifications, in-work support, occupational health services, education and training.[12] [13] [14] [15] Fit notes can provide an understanding of adjustments required for employees to return to work. Awareness raising is also needed to develop an inclusive culture.

Individuals with co-occurring conditions and multiple disadvantages are among the most vulnerable in society. There is often a gap in provision for this group as they have complex needs and do not engage with traditional pathways and have poor service retention – often presenting in crisis. Acute healthcare settings, criminal justice, mental health, housing, social care and substance use commissioners and services should develop a joint strategy with strong system leadership and information-exchange arrangements to ensure continuity of care between services. Service access criteria should not exclude

people based on levels of substance dependence, or on diagnoses (or lack of diagnoses) of mental illness, and the principles of 'no wrong door' and 'everyone's business' are evidenced in commissioning, service delivery and practice.[16]

### Suggestions for MSK

17.1 million people in England alone have an MSK condition and pain resulting from these conditions has been identified as a risk factor for 'poor work ability', early retirement, health related unemployment and sickness absence. [17] [18] In fact, it is estimated that over 30 million working days are lost due to MSK conditions annually in the UK. [19] Prioritising prevention, long term care and management could translate to major economic gains by supporting and encouraging more people to work. Preventing MSK and supporting those with MSK to manage the condition would be mutually beneficial for businesses and for those individuals.

Considering that MSK symptoms can be induced by work-related injuries and unsuitable home office environments, it is crucial that the Government support and encourage employers to take on a health improvement role in the workplace.[20] The workplace has an important role in the wider community to create working conditions that focus on prevention and improve employees' health and wellbeing particularly in the case of MSK. The Government should support and encourage businesses to provide in work support services, employee assist programmes such as occupational health services, as well as trainings on MSK conditions and on developing healthier environments. Employers should take the lead in ensuring workplaces promote healthier lifestyles and make it easier for their employees to quit tobacco use which is key considering that smoking exacerbates MSK pain and symptoms.[21] Businesses should adhere to the NICE Quality Standard 147 and NICE Guideline 13 and sign up to a healthy workforce pledge.[22] [23] Lastly, we would also like to see support for employers to enable them to embed effective sickness absence management as a key tool to support people when they are off sick, ensure they come back to work, and then do not drop out again.

The Government should take a whole system approach to work and health and adopt a health in all policies approach to decision-making in order to maximise positive health outcomes and gains to healthy life expectancies. It is important that the Government consider the role of the NHS and ensure prevention forms a key, mandatory and funded part of all ICS plans to ensure a healthy working population in the future.

### Suggestions for dementia

The social care system is crucial in supporting people who are diagnosed with dementia. However, social care is currently under a tremendous amount of financial pressure which further highlights the importance of prevention to ease the pressure. In November 2022, the Autumn Statement announced new funding for adult social care, with up to £2.8 billion in 2023/24 and up to £4.7 billion in 2024/25.[24] However, The Local Government Association (LGA) feels it is unlikely that the full £2.8 billion will be received in 2023/24. Despite the increased funding we are now also facing a lack of staff across social care services. The Association of Directors of Adult Social Services (ADASS) released a report in July 2022 which highlighted that vacancies in adult social care roles were up 52%.[25] Sustainable funding of the social care funding system is extremely important for older people's wellbeing and dignity and must be addressed as a matter

of urgency. Action is also needed on the commercial determinants of unhealthy ageing such as smoking, excessive alcohol consumption and poor diet. This will help to increase healthy life expectancy, delay the onset of long-term conditions, and ease pressure on social care.

Recently, Lecanemab has been introduced as a new drug for people living with early-stage Alzheimer's disease. During the clinical trial, some people experienced reactions to having the drug infused, while some were found to have swelling or microbleeds in the brain in response to the drug – known as Amyloid Related Imaging Abnormalities (ARIA). It is crucial to scrutinise the drug carefully and ensure that it is safe and effective before making it available to patients in the UK.

Q12: Do you have any suggestions on how we can better enable health and social care teams to deliver person-centred and joined-up services? [Yes/No]

Yes

Q13: How can we better enable health and social care teams to deliver person-centred and joined-up services?

You might consider suggestions to improve the skill mix and training of the health and social care workforce.

## Suggestions for multiple conditions

### Joined-up services

A longstanding challenge for primary and community care is to adapt existing healthcare structures and better integrate services within the wider health and care system. The system architecture is complex, with accountability and governance arrangements for the main system partners – LAs and NHS bodies – running through different lines. Further consideration is therefore needed around how the ICB and ICP will work together and be held to account through the different accountability mechanisms for LAs and the NHS – how will national accountability to NHSE be balanced with local democratic accountability? The role of elected members on these boards also needs to be considered.

It is vital that the roles and responsibilities of all partners are understood, respected and resourced. This includes valuing the role of LAs as an equal partner within the ICS and recognising the different perspectives of LA colleagues – including DsPH, Directors of Adult Social Services, Directors of Children's Services and Chief Executives. There should also be devolved funding for health and care in local places so there is more flexibility with joined up budgets.

A whole system approach that goes beyond the NHS is crucial to facilitate joint national, regional, and local actions from all sectors. Policymakers must acknowledge the wide variation between local systems and be realistic about what different areas can achieve. Furthermore, outcomes and goals that are set nationally, also need to make space for local leaders to agree shared outcomes that meet the particular needs of their communities.[26]

Information sharing is widely recognised as a major enabler for the delivery of integrated care. The ICS needs to allow for robust data flows across organisational boundaries with the geographical granularity and timeliness to support local action and meet the needs of local users, including DsPH. Effective data sharing can enable ICSs to take a targeted, data-led approach to designing and delivering services, reducing inequalities and improving population health.

### Peron-centred care

To achieve whole-person care, there is a need for a shift in the NHS policy towards generalist care to treat multi-morbidity which has implications on resources within the NHS. This requires efforts from not only the hospitals, but also local public health teams. It is important to build on good practice and ensure effective collaboration.

In addition, there should be an inclusive approach to engage communities and disadvantaged groups in the design and implementation of programmes. This can improve health through the development and delivery of more appropriate and accessible interventions. Furthermore, community engagement has a direct positive impact on social cohesion, development of social capital, individual self-esteem, and self-efficacy for those who are engaged.[27]

### Suggestions for CVD

Behavioural and clinical interventions delivered to one person at a time can result in intervention generated inequality, eg people that who have completed higher education and come from less deprived communities are more likely to do health checks. Therefore, to tackle CVD, it is crucial to shift from individual change to a change in policies and system so that there could be health improvement for many instead of for a few. This could enable a joined-up approach to cater for population needs.

CVD prevention is not just about health checks. Structural interventions that act on commercial and social determinants of health (eg tobacco and food environment) and shift population behaviour will be cheaper, more equitable and will have more of an impact. The focus should move from downstream treatment to upstream preventative action. There should be a whole system, joined-up approach involving transport, planning, health, education, and businesses to create a healthier environment.

There should be a clear and effective primary care pathway across acute, generalist and specialist care for CVD that caters for multi-morbidity, so that there can be a better system for serving patients with complex needs. Lessons should also be learned from the National Service Framework which put in place networks and standards that enabled dramatic improvement in clinical areas over decades.[28] Networks, collaboration and partnership working are crucial in CVD prevention and improving standard of care.

Formation of Integrated Care Boards (ICBs) and ICSs provides an opportunity to work collaboratively and reinvigorates focus on CVD. It is important to ensure that ICSs are aware of established public health resources and how to access them to build population health capacity in the most integrated way (eg NHS's guidance on ICBs).[29] Since capacity is limited across the system, it is important to be clear how various expertise in the system is best utilised. Public health should take a system leadership role to co-ordinate effort and support the NHS to implement quality improvement methodologies for CVD prevention pathways improvements.

In terms of funding and resources, cutting-edge precision medicine comes with enormous opportunity cost at the expense of public health investment, primary care and social care, and the chances that it will produce high marginal value or return to health is slim. More investment should be dedicated instead to primary prevention which is three to four times as effective in reducing mortality than the NHS.

We support NICE's guidance which provides recommendations on CVD prevention at population level.[30] It is crucial to establish the evidence base of what works and understand the impact, outcomes, and cost effectiveness of interventions (eg health checks) on awareness raising as well as primary and secondary

prevention.[31]

## Suggestions for chronic respiratory diseases

A joined-up approach to CRD requires a whole system focus on prevention and getting people diagnosed quicker. Once a person has been diagnosed with a condition such as chronic obstructive pulmonary disease (COPD), their symptoms can be managed but ultimately these diseases are not curable.[32] Symptoms such as shortness of breath will significantly impact a person's quality of life including their ability to exercise and work, both of which are vital components to lead a healthy and long life. In fact, in 2022 respiratory conditions overtook mental health as the fourth most common reason for work sickness absence and the proportion of sickness absences caused by respiratory diseases has doubled since Covid-19.[33] Therefore, the Government should ensure they are taking adequate action on smoking and air pollution as they have been identified as major risk factors for CRD.[34] We suggest that in order to tackle CRD caused by smoking, the Government should consider implementing measures such as revising the tobacco tax escalator so that it is 2% above average weekly earnings rather than RPI and raising the age of sale of tobacco from 18 to 21. More recommendations on tobacco control can be found in our answer to question seven. Air pollution is another risk factor to CRD, and contributes to over 20,200 respiratory and cardiovascular hospital admissions per year.[35] Damp housing and poor insulation can also lead to poor indoor air quality and increased CRD risk. Therefore, alongside smoking the Government should put in place measures to limit the detrimental impact of air pollution on people's health. In particular, we would like to see the Government set out a clear, funded plan to achieve the WHO's air quality standards, outlining the role of local authorities. The Government should also prioritise active travel in transport policy and continue to invest in infrastructure for active travel. This should be set out clearly within appraisal and modelling strategies. Infrastructure to support walking, cycling and use of public transport needs to continue to be developed.

## Suggestions for dementia

A joined-up approach to dementia requires a focus on prevention and interventions that prevent the condition from worsening and making it more manageable. Although not all dementia is preventable, The Lancet Commission identified nine modifiable risk factors which could prevent more than a third of dementia cases: low educational level in childhood, hearing loss, hypertension, obesity, smoking, depression, physical activity, social isolation, and diabetes.[36] Delaying the onset of dementia by one year could prevent more than nine million cases of dementia by 2050,[37] while delaying onset by five years could halve the prevalence of dementia globally.[38]

There should be joint working across local and central governments and between health and community partners on the key risk factors of dementia:

- **Loneliness and isolation**[39]**:** Over one million older people report that that they always or often feel lonely.[40] Action is needed to address the root causes of isolation eg digital exclusion, access to public transport, and ageism. Older adults should be supported to live independently by working closely with the VCS. Activities like volunteering and employment also support healthy ageing. In addition, older adults should be provided with equal opportunities to apply for and remain in employment if they choose to.

- **Lack of physical activities:** Age-appropriate infrastructure is important to enable active travel amongst older people. This requires an integrated approach to the planning and design of cycle lanes, walking routes, safe crossings, level pavements, and the location of amenities and services.
- **Commercial determinants of health:** Obesity, smoking and alcohol consumption are all key modifiable risk factors of dementia.[41] More recommendations could be found in our answer to question seven.
- **Health inequalities**: Dementia is more prevalent in Black and South Asian ethnic groups than white populations.[42] Low educational level in childhood has been identified as a key modifiable risk factor too.[43] In addition, more women die of dementia than men (for reasons more complex than women living longer).[44]

Q14: Do you have any suggestions on how we can make better use of research, data, and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions? [Yes/No]

Yes.

Q14: How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

### Suggestions for multiple conditions

It is important that DsPH have access to high quality intelligence to carry out their statutory responsibilities and tackle the major conditions. Accessible, quality data and digital technologies would enable research and evidence-based interventions that could prevent the major conditions.

A systematic review of barriers to data sharing in public health by Panhuis et al. identified 20 unique real or potential barriers.[45]

- Technical: Public health teams often struggle with the research questions and data collected not being directly applicable to the sorts of problems they are trying to solve.
- Motivational: Frequently large organisations, such as the NHS, are not sufficiently incentivised to share information with local public health teams. Similarly, disagreement on data use from large organisations is a barrier to sharing data with public health teams (such as policing or housing data).
- Economic: Local public health teams frequently do not possess the workforce or computational equipment to analyse public health data.
- Political: Restrictive policies on access of public health data, brought in under the 2012 Health and Social Care Act, combined with the lack of official guidelines on data sharing both affect DsPH ability to access data.
- Legal: Protection of privacy is a major obstacle for DsPH when accessing patient identifiable data (PID). General Data Protection Requirements (GDPR) and the lack of understanding of its application are also major obstacles for data sharing.

Measures should be in place to address these obstacles. Robust and complete data and intelligence should flow across organisational boundaries in a timely manner, including from/between the NHS, UKHSA, and OHID. Public health teams need access to high quality data, and guidance or frameworks for how to share

and access the data, such as the NHSX data strategy.[46]

Improving the data infrastructure could allow public health professionals access to evidence on the major conditions. There is a need for data warehouses that allow local data to be securely stored, linked and used across agencies for the public good. It also requires the development of the analytical workforce and better harnessing of their skills, both locally and nationally. Public health analysts are scarce not only due to lack of definitive career pathways, but also as a result of there being a lack of infrastructure.

Currently, due to poorer access to health services some groups may be under-represented in NHS datasets and therefore use of this data might not equitably benefit patients from these groups.[47] Measures should be in place to ensure that research is based on data representative of all population groups.

### Suggestions for CVD

Many LAs are finding alternative methods to increase hypertension detection in communities, data sharing and linking back records to primary care a real issue. Digital Health Checks could potentially provide some solutions, but the current discovery phase seems to be remote from GPs LCSs and CVD Secondary Prevention discussions. GP LCSs on LTCs and prevention need to be widened in order to be sustainable, including wider primary care such as pharmacies and dentists. Health checks for LDs, Looked After Children and people with SMIs can be integrated into one pathway. It will be hard to evaluate if this system is effective if data sharing pathways are not linked.

Some ICSs/ICBs have developed comprehensive Population Health Management tools to link primary care, secondary care and social care data. Data sharing agreements at the national level would assist in making these tools work more easily at the local level. The database should also allow individual level data to be linked across multiple datasets and policy areas. DPH access to local primary care data could assist in ensuring CVD prevention pathways have feedback loops and data is analysed in real time to inform targeted interventions. It will also be useful to explore whether CVDPREVENT is used and utilised in primary care as a quality improvement tool and if each locality has an identified CVD clinical lead that can champion CVD quality improvement methodology.

## Mental Health

Q19: How can we better support those with mental ill health? (Please do not exceed 500 words)

Support needs to be holistic, include social support and be far broader than clinical interventions. Mental health provision needs to include more robust community support to enable people to live safely outside hospital. There are models across the world (eg Trieste in Italy) where the focus has been on building community support infrastructure and positive activities and we should learn from those good examples.

Mental health is closely related to social determinants of health such as housing, employment, financial stability and education and these are often intertwined. A whole system approach is needed which identifies opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at key life stages from preconception, during pregnancy, through infancy, childhood, working and family building years, and into older age. Such an approach requires partnership working across schools, the NHS, the police, housing associations, VCS organisations and other key stakeholders. Local areas should be supported to adopt a place-based approach that focuses on high quality housing,

financial stability (including employers paying living wages, getting all entitled benefits, debt reduction advice, etc), good employment, training and education, green spaces and physical activity and increased social capital.

It is estimated that 25% of people with mental health issues in England cannot get access to the treatment they need.[48] Mental health patients are often unable to access care due to long waiting times, a lack of 24/7 crisis care and a high threshold for specialist mental health support, as well as poor integration of mental health services with other local services.[49] Approximately 26% of referrals to CAMHS were rejected in 2018-19, amounting to 133,000 children and young people despite an additional £1.4 billion committed from 2015-16 to 2020-21. Average waiting times for these services have improved, however on average a child still waited two months to begin treatment – double the Government's four-week target.[50] Improving access to mental health services is vital as many people can make a full recovery if they receive appropriate support and treatment at the earliest possible stage. Services that support people who may be experiencing poor wellbeing for the first time or episodic symptoms of mental illness may benefit from community support services (as an alternative to psychological therapies) encouraging physical activity, greater social contact and training opportunities. In addition, suicide prevention strategies and interventions need to be multi-disciplinary, combining a range of integrated interventions that build individual and community resilience and target groups of people at heightened risk of suicide. Many local areas have taken the initiative by implementing 'zero suicide' strategies and creating partnerships.

As more deprived communities are at greater risk for poor mental health there should be an explicit focus on addressing health inequalities. ADPH would like to see a more prevention-focused, public health approach to mental health and wellbeing in the population. Current strategies and approaches are too focused on managing existing mental health conditions, rather than promoting mental wellbeing and building personal resilience.

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