

People's Health Trust response to the NHS Ten Year Plan consultation: December 2024

About People's Health Trust and our network of experts by experience

People's Health Trust is a national charity with over a decade of experience working with local communities across Great Britain to address health inequalities through the building blocks of health. We have raised over £133 million to support more than 3,000 grassroots and community organisations, reaching almost 800,000 people in Britain's most disadvantaged neighbourhoods.

To inform this submission, we convened two roundtable discussions with our network of experts by experience (comprised of current and recently funded partners), as well as a survey, hearing testimony from 42 grassroots community organisations from across the country. These organisations are working with more than 20,000 residents in neighbourhoods experiencing some of the sharpest health inequalities in England. Our submission focuses upon what prevention should look like. These community leaders shared their views and experiences with us, and almost two thirds of partners surveyed said that local health services are meeting local people's needs badly or very badly. Their contributions highlighted their depth of experience in practical prevention work in the most disadvantaged communities, their crucial role as an early warning 'intelligence' system regarding health and social issues emerging for people, and some quite mixed experiences of their engagements with NHS Trusts and Integrated Care Boards.

Summary recommendations

- Make improving outcomes and narrowing the health inequalities gap a key milestone of each of the Government's five missions
- Introduce Health Inequalities strategy for England which is cross-departmental.
- An equity approach to prevention through ensuring those areas with the worst health and the longest delays receive targeted support through NHS funding formulas.
- Close collaboration through Integrated Care with local authorities, public services, and civil society, prioritising grassroots and hyperlocal organisations
- A plan to meaningfully engage with minoritised population groups and representative organisations to better serve them. Adopt of the recommendations of the Hewitt Review, to bring about more localised approaches to health and care.
- Engage with older people's groups, minoritised ethnic groups, refugees and asylum seekers, homelessness charities to understand needs of people who are more likely to be digitally excluded.

What we see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health

The vital role of prevention for better population health

People's Health Trust strongly believes that prevention work cannot succeed if it is taken on by the NHS alone. Secondary and tertiary prevention are critical functions and services, but as a sole focus they will overwhelm any health system - as they have the NHS. Without a national primary prevention agenda guided by a Health in All Policies approach and a cross-departmental Health Inequalities strategy, NHS England's work to reduce the impacts of disease, injury and illness will never reduce the incidences of them.

The primary goal of prevention work must be better population health. A Health in All Policies approach is one that systematically embeds consideration of the population health and health inequalities implications in all significant policymaking. We strongly believe that primary prevention should be within the scope of this consultation and at the heart of a strategy surrounding the new Ten-Year Plan. The building blocks of health, also known as the social or wider determinants of health are the overwhelming drivers of the nation's health and need to be seen and addressed as such if the government truly intends to prevent ill health. There is strong evidence to support our view that a primary prevention focus is the biggest enabler to tackling the causes of ill health, domestically and internationally. Crucially, a host of health issues the population and consequently the NHS face, are causally linked to social and economic issues. The absence of a primary prevention agenda is by extension one of the biggest challenges for the NHS, its capacity, and its primary and secondary care workforce. If the NHS and Department for Health and Social Care work in silo rather than collaborating across government departments and with civil society, the government risks missing the opportunity to act on the intersecting socio-economic drivers of ill health.

We are not calling for primary prevention alone. Such a focus needs to sit alongside the NHS reorientation required to improve services and the speed with which people can access GP appointments, hospital appointments, treatments and referrals. While we acknowledge these are two pathways, they should not be so distinct as to prioritise the secondary and tertiary prevention which leave primary prevention relatively untouched, risking a re-iteration of the current health inequalities crisis in another ten years. Closer engagement with the socioeconomic drivers of ill health can and should be incorporated into efforts to cut waiting lists and improve care. Wider and deeper rollout of Community Linking in general practice nationwide, or the incorporation of voluntary and community sector organisations into Integrated Neighbourhood Teams to facilitate a reduction in non-medical appointments, as is being piloted in Gateshead (which we, alongside NHS England, part-funded), are two ways to explore this. The closer integration of public services, the voluntary sector and Integrated Care at local and regional levels, which is showing promise in some parts of the country already, should be the platform through which the meeting of shared goals and targets is achieved. But this joined-up, collaborative work needs to also be taking place at the national level. The new Joint Work & Health Directorate, supporting the plan to Get Britain Working, is one such example of how this can work nationally.

This is long-term work, but it is urgent it begins now. The nation's health, particularly in the most disadvantaged areas, has been worsening for some time and health inequalities

widening. The evidence of the last decade makes clear that inaction will only accelerate these alarming trends, undermining population health, living standards and economic prosperity.

Relatedly, we remain concerned that some of the major issues impacting the NHS, such as obesity, are perceived to be fixable through individual lifestyle changes and technological solutions. This approach fundamentally misunderstands the complex factors that contribute to obesity, to give just one example. Lifestyle interventions are also least successful with people on lower incomes, for whom the prevalence of obesity is highest, because of the cost and availability of healthy foods and exercising as well as poor regulatory control over the availability of harmful foods.

Taking an individualistic focus can be seen across a host of health issues, including the impact of cold homes on coronary heart disease and strokes, which spike excess winter deaths, or respiratory conditions caused by poor housing conditions. Fundamentally, prevention requires examination of the causes of health issues. Housing is a clear example where collaboration between the health system, local authorities, public services, and the voluntary and community sector can pay real dividends. Local authorities across the country are actively recruiting Environmental Health officers to better address poor housing conditions and to seek to improve enforcement of the social and private rented sectors, driven in part by the tragic death of Awaab Ishak as well as the government's mandate to improve housing standards. This work aligns closely with the Core20PLUS5 goal to focus on COPD in the most deprived 20% of neighbourhoods in England, where the disproportionate burden of poor housing is found. Working in collaboration on this issue and aligning efforts, time and resources would in time lead to better COPD outcomes for the NHS, better housing conditions for councils, and ultimately better homes and better health for communities.

People's Health Trust has a pilot programme called [Homes for Health](#), through which we fund and support community organisations with experience working on housing to influence improvements to housing conditions for tenants, by engaging housing staff, health leaders and landlords and letting agents. Our attempt to address housing needs in ways which make sense locally are about working with existing systems and statutory services to improve housing and therefore health.

The need for an equitable approach to prevention

People's Health Trust strongly believes that work on primary, secondary and tertiary prevention must adopt an equity approach. Focusing attention and investment where health inequalities are sharpest, health outcomes are worst and health services most overwhelmed will provide the surest path to meeting the government's stated goal to close the healthy life expectancy gap, which presently stands at more than 18 years for both males and females in England. More targeted support is required in the most disadvantaged areas, where waiting lists for physical and mental health services are longest. A 2023 King's Fund report found the people in these communities were more than twice as likely to wait more than a year for elective care as people in more affluent areas. Our network of grassroots community organisations has repeatedly confirmed to us over the last four years that mental health need in particular is at crisis point in disadvantaged neighbourhoods. As one community leader based in an area of significant deprivation told

us, “If we signpost to health services, there’s no capacity at all. Mental health services ... are in an astonishing state. I have to bite my tongue when people need help, knowing they won’t be seen for at least six months.”

We call on the NHS to take a position of proportionate universalism, ensuring those areas with the worst health and the longest delays receive targeted support through NHS funding formulas. Focusing where need is sharpest is not only a practical way to improve the averages of metrics such as waiting lists, but it is also a matter of fairness. As the NHS Constitution states, everyone counts, and resources should benefit the whole community. It is clear they presently do not.

Closer integration with communities

The grassroots organisations we spoke to called for a similar approach to that which we have outlined at the national level to be taken at local and regional levels. The hallmarks of integrated work are already taking root regionally through Integrated Care Boards and Partnerships, and in some places locally through new Health Hubs and Integrated Neighbourhood Teams. Integrated care carries significant potential to take a holistic and joined-up approach to health alongside local authorities, wider public services, and the voluntary and community sectors. There are many promising examples of this sort of work taking place across the country, although it is far from consistent and there is a need for good practice to be both shared more widely and encouraged by regulators.

One community leader, based in a semi-rural former mining town, described joined-up work between their community organisation, faith groups, the JobCentre, various NHS services including GPs and the local food bank resembling a systems approach:

“We have a place-based partnership which works quite well. We get referrals from all these places to help with various things. It saves a lot of people from going into the NHS with those early interventions - we’re the ones preventing people’s isolation tipping them over the edge into mental ill health. Social interaction has been lost - we’re working to rebuild that community infrastructure.”

This touched on a common theme amongst the community organisations we heard from: in the context of decreasing public health budgets, stretched statutory services and negligible attention to prevention, it is these grassroots voluntary and community organisations who have been on the frontline delivering preventative services for some time. We therefore strongly advocate for their involvement in local public health structures, including in commissioning models. Many community leaders we spoke to highlighted the ways their approaches differ to primary and secondary care:

“People come to our drop-in with mental health problems, ongoing physical health problems, disabilities and additional needs. Some have dementia. It’s people with nowhere else to go. The difference between us and lots of statutory services is we’re accessible straight away, and we look at the whole person: their social, physical and mental needs.”

While charities and community groups offer more holistic services and activities for the public, we are not suggesting health services take this approach to intervention - but that systems closely engage with the organisations that can and do work in this nuanced and tailored way, and benefit from their expertise and insights.

It is our experience that grassroots community organisations are excellent at raising early warnings regarding concerns for population health which first emerge at the neighbourhood level, particularly in those communities experiencing significant disadvantage. This includes financial and food insecurity early in the pandemic, rising mental ill health amongst young people and minoritised ethnic groups in recent years, the continuing health impacts of the high cost of essentials for people earning low pay and/or in receipt of Universal Credit, and more recently increasing social isolation, stress, and anxiety amongst older people [as a consequence of cuts to the Winter Fuel Payment](#). This proves how effective an early warning system civil society can be, and it would be of benefit to the NHS to view voluntary and community sector organisations this way. Our ability to respond to local need has benefitted from having this information weeks and months before increasing footfall to and referrals for mental health services reportedly rose sharply.

Beyond the immediate physical health impacts of issues such as air pollution or poor housing conditions, one of the main pathways through which social determinants of health impact people is through stress and inflammation. There is a wealth of academic literature exploring the biomechanics of social adversity, the immune system and chronic disease. Given the increasing prevalence of cardiovascular disease, COPD, musculoskeletal conditions and other complex, long-term conditions which not only play a major role in the nation's declining population health but also in delays to hospital discharges, we believe it would be prudent for Integrated Care Systems to work closely with the organisations mostly deeply-rooted in communities, who hold the intelligence surrounding the ebbs, flows and drivers of mental and physical ill health.

As noted earlier in this submission, there are examples of promising work in this area. West Yorkshire ICB is one: they publish an annual involvement report highlighting how they are engaging with communities. They co-developed an involvement strategy that prioritises sharing knowledge and information from services to communities and communities to services as well as ensuring services are working more relationally with local people. They are working through more localised Health and Care Partnerships with a host of voluntary and community sector organisations representing different population groups and people with specific conditions within the region to ensure the views and needs of patients, carers, families, and communities are heard and integrated into their work.

The need for stronger engagement with communities

While Integrated Care Systems are mandated to engage with the voluntary and community sector, many community organisations told us their interactions were not satisfactory: in some instances, they described a culture of consultation upon consultation, evidence gathered not being absorbed and acted upon, and in some cases feeling neither respected nor valued.

"It can be really helpful and useful [to engage], but you sit around the table and might be the only person there that's actually seen a family in crisis. You're the only one not paid to sit there, you're there because it's the right thing to do. But there's an overload - it just keeps coming. You keep getting asked and asked, they keep consulting and consulting."

“We’ve engaged with the local NHS on consultations. Half the time it’s just a talking shop; they don’t take much notice. Their attitude tends to be they’re the professionals, they know what’s best, they will decide - they use consultations to tick boxes. They totally disrespect the voluntary sector; they think it’s a waste of time. We’ve overheard directors say not to waste time with volunteer organisations, that they know best. They need to come with positive views, take notice of what we say, and mean they want to hear from us.”

While we do not wish to suggest the above quote represents all ICS engagement with voluntary and community organisations, it does point to inconsistent experiences in different places. We surveyed those who engaged with us to ask how they feel health services are meeting the needs of residents in their community at the moment. 25 per cent said very badly, 45 per cent said badly, 30 per cent said moderately, and no respondents said either well or very well. Closer and more genuine engagement with service users is one clear way to ensure the needs of people with the worst health are understood.

How do you feel health services are meeting the needs of residents in your community at the moment?

Think about GPs, local hospitals, mental health services, social care services, and any others you have engaged with or heard about.

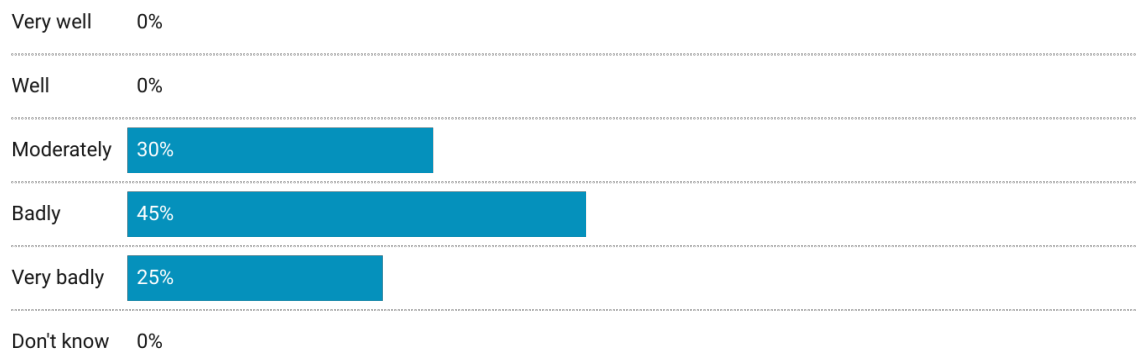


Chart: People's Health Trust • Source: Survey to support NHS consultation response, People's Health Trust, October-November 2024. n=20 • Created with Datawrapper

This was a strong and recurring recommendation from the groups we spoke to, with experience working with health systems: for genuine engagement, participation, and co-production over consultation. Many groups also told us they find it very difficult to find entry points into health systems when they wish to engage, but may not already be on health systems’ radars.

Community organisations who are regularly involved were also clear that health systems should compensate them for their time and input, noting they are frequently the only unpaid people at strategy meetings, which poses a host of challenges in the context of immensely stretched finances and capacity in the voluntary sector:

“Sadly, it all comes down to money and funding. There’s a struggle, despite ever-increasing demands and needs. We’re saving huge costs to the NHS, and do it on a shoestring.”

“We get invited to engage by services a lot, but to be honest we have to focus more on fundraising and keeping the organisation above water. They have all these consultations, you don’t get paid to engage. Every hour spent is an hour I’m not trying to raise money somewhere else.”

“You need a strong civil society as a bulwark for the health service.”

One group of respondents suggested that where community organisations are trusted to receive referrals through social prescribing, they should also be trusted to refer people in crisis back into services themselves, in cases where they are unable to meet their serious and immediate clinical needs.

Closer integration with voluntary and community organisations through integrated care, as well as anchor approaches, is also a key recommendation of the Marmot Beacon Indicators developed by the UCL Institute of Health Equity.

Prevention, minoritisation and inclusivity

In the engagement events for this consultation and in prior research ([People’s Health Trust, Response to DHSC Mental Health and Wellbeing Plan, 2022](#)), it has been made clear to us that community organisations supporting and working with people belonging to minoritised ethnic groups are especially likely to be the first port of call when people belonging to these groups need mental health support. Wider evidence as well as our own finds a significant disconnect between minoritised ethnic groups and their local health services. In the context of the wider discrimination minoritised ethnic groups experience leading to inequalities in employment, housing, air quality, access to green space, interactions with the justice system, amongst others, this only exacerbates the health inequalities they already face.

“There are so many barriers for [an ethnic group] within community, culture, and the system. There are housing problems. It all interconnects. It leads to social isolation, but mental problems can be taboo. And then it just worsens and worsens.”

Key recommendations from community organisations to combat this include work to seek to destigmatise accessing healthcare, particularly mental health; finding ways to combat wider discrimination, including the ways in which services respond to minoritised ethnic groups; and communication, particularly who is delivering messages to communities.

These recommendations point to systemised outreach work in some health services which seeks to inform rather than meaningfully engage and collaborate. Universal approaches often leave many people behind, without consideration of language, cultural or social norms.

Incorporating representative voluntary and community groups into the design of service engagement plans, rather than seeing them as messengers, is key to helping combat stigma around health, to building trust through increased cultural sensitivity, and enhancing the reach of health services into the communities that systems frequently deride as being ‘hard to reach.’

People’s Health Trust co-funded a Lozells Health Commission, made up of local residents and community leaders in the wake of significant health inequalities exposed in the

Birmingham borough during the Covid-19 pandemic. The commission uncovered significant inequalities in chronic disease, life expectancy, service engagement and representation in local and city-wide health structures for residents, who are predominantly Bangladeshi and Pakistani. The recommendations of the Commission’s final report were: to enhance

accountability and representation for groups affected by health inequalities on the Birmingham Integrated Care Board, for the Director of Public Health to improve data collection and transparency around community health needs, a clear neighbourhood action plan to address socioeconomic determinants of health in the area, and for further research into the causes of the most acute issues in the area, which are housing issues and mental health services. These are the sorts of recommendations, thematically, that can address health inequalities particularly when amplified by discrimination and marginalisation.

A neighbourhood approach

In the spirit of the recommendation to go to community groups working with minoritised ethnic groups, People's Health Trust also recommends NHS England steer Integrated Care Systems to work more locally. More localised approaches to health are being embedded in a few locations, including West Yorkshire ICB, outlined above, as well as North Central London ICB. Most voluntary and community organisations do not work at the same geographic scale as Integrated Care Boards and we therefore call for all Boards to implement mechanisms for gathering localised intelligence and engaging meaningfully with often hyperlocal grassroots community organisations.

This echoes a key recommendation of the Hewitt Review into Integrated Care.

People's Health Trust welcomes the development of Health Hubs at the local level in pockets of the country to take forward a more integrated approach to community health. We recommend NHS England support the spread of Health Hubs, as well as encourage them to ensure they are engaging with voluntary and community sector organisations, to facilitate a more holistic, whole-person approach to care and ensure that people attending for non-biomedical reasons are still able to swiftly receive the support they need.

What we see as the biggest challenges and enablers to making better use of technology in health and care

The 42 community organisations we convened had a number of recommendations pertaining to making better use of technology in health and care. They favoured deeper technological integration of health and care services as a way to streamline booking appointments, but raised a series of concerns regarding segments of the population likely to be marginalised by this shift unless their needs are met.

They reported significant numbers of people in the most disadvantaged communities having English as a second or third language. They recommended seeking to build multiple languages into digitised care such as the NHS app or appointments platforms, in order to not further exclude those who are already marginalised and are disproportionately likely to live in poor health.

Community leaders also highlighted the needs of population groups facing digital exclusion, particularly older people, disabled people and people with a learning disability, and people living in poverty (relating to the costs of smartphones or tablets, phone and Internet contracts). They made clear that there needs to be the option - potentially through local Health Hubs - for those facing digital exclusion to be able to book appointments and have parity of care, perhaps with the support of staff to use community-use tablets or to do so verbally.

They also made clear there is a great deal of expertise in community approaches to tackling digital exclusion, citing the National Digital Inclusion Network which the NHS could seek to engage with.

People's Health Trust recommends NHS England engage with charities representing the segments of the population most disproportionately affected by digital exclusion, such as older people, minoritised ethnic groups, refugees and asylum seekers, people experiencing homelessness and people living in absolute poverty in order to work through potential barriers to care, as well as with organisations expert in digital inclusion such as Good Things Foundation.

What we want to see included in the 10-Year Health Plan

1. Make improving outcomes and narrowing the health inequalities gap a key milestone of each of the government's five missions. Within this, the development of national primary prevention agenda and frameworks, specifically a Health in All Policies approach which will mandate all policy creation to assess the impact on health and on health inequalities. This should be done urgently.
2. To support the missions work above, introduce a cross-departmental Health Inequalities strategy for England, reviewed every five years which includes both specific achievements and routes to accountability.
3. An equity approach to prevention, addressing health inequalities through assignment of spending using proportionate universalism considerations, ensuring those areas with the worst health and the longest delays receive targeted support through NHS funding formulas.
4. Close collaboration through Integrated Care with local authorities, public services, and civil society to identify shared goals around and take action on the social determinants of health. This can support efforts to reduce waiting lists and increase the quantity and quality of care and should include an expansion of Community Linking and collaboration between Integrated Neighbourhood Teams and the voluntary and community sector. Close collaboration with civil society should prioritise grassroots and hyperlocal organisations, including meeting them in place, valuing their time and expertise, and utilising their intelligence and insights to provide a more joined-up approach to population health, and to ensure that engagement-by-consultation is disincentivised.
5. Acknowledgement that health services have some way to go to provide appropriate care to minoritised population groups, and a plan to meaningfully engage with them and representative organisations to better serve them. Adoption of the recommendations of the Hewitt Review, to bring about more localised approaches to health and care, and Integrated Care Boards implementing mechanisms to gather and share localised intelligence with grassroots community organisations should support this endeavour.
6. Engage with charities representing the segments of the population most disproportionately affected by digital exclusion, such as older people, minoritised ethnic groups, refugees and asylum seekers, people experiencing homelessness and people living in absolute poverty in order to work through potential barriers to care, as well as with organisations expert in digital inclusion.

All of these recommendations for change could be implemented within the next year or two years.