Department of Health & Social Care

Major conditions strategy: call for evidence

The Department of Health and Social Care (DHSC) is launching a call for evidence to inform the development of the major conditions strategy designed to tackle ill health, reduce the number of people out of work due to ill health and ease pressure on the health system. We are seeking views and ideas on how to prevent, diagnose, treat, and manage the groups of major conditions which drive a large proportion of ill health and early death in England, namely:

- cancers
- cardiovascular diseases (including stroke and diabetes)
- chronic respiratory diseases
- dementia
- mental ill health
- musculoskeletal disorders

As well as seeking views on individual condition groups, this call for evidence requests ideas on how to tackle the behavioural risk factors common to the major condition groups and how to improve the care and outcomes for those suffering with one or multiple conditions. This builds on the calls for evidence on cancer and mental health last year. These provided very useful insights which we will be considering in the development of the major conditions strategy.

Please review the full consultation page before completing this survey. This strategy applies to England only.

This consultation closes at 11:59pm on 27 June

To share this survey with others, please right click to copy this direct link address and paste it. Do not share the page to the survey once you have started it. If you navigate away from the survey, the survey will continue from where you left off as long as you reopen the link in the same browser.

About you

In what capacity are you responding to this survey?

- An individual sharing my personal views and experiences such as a patient, carer or member of the public
- [✓ An individual sharing my professional views such as a healthcare professional or on behalf of my organisation]
- A joint response on behalf of two or more organisations

Your organisation

Which of the following best describes how are you responding to this survey? (optional)

- As a health or social care professional
- On behalf of an NHS organisation or social care provider
- On behalf of an independent health or social care provider
- On behalf of a Clinical Commissioning Group or Integrated Care System
- On behalf of a local authority
- On behalf of a royal college
- [✓ On behalf of a charity or third sector organisation]
- As a pharmaceutical industry professional or company
- As an academic, researcher or on behalf of a university

What is the name of your organisation (or organisations if submitting a joint response)? (optional)

Homecare Association

Where does your organisation operate?

- [✓ England]
- Wales
- Scotland
- Northern Ireland
- Outside the UK

As part of this survey there are a few reasons we may require your email address:

- if you need to contact us about amending or deleting your response - the only way we can verify that it is your response is via your email address
- if you didn't have time to finish the survey, we can send you a reminder before it closes.

If you are responding on behalf of your organisation, please provide your organisational email address. Your email address will not be shared with anyone outside of the department.

Are you happy to share your email address with the Department of Health and Social Care?

- [✓ Yes]
- No

What is your email address?

policy@homecareassociation.org.uk

In this part of the survey, we are interested in your views on what types of intervention we should prioritise for each condition.

Would you like to answer questions about cardiovascular diseases?

- [✓ Yes]
- No

Would you like to answer questions about chronic respiratory diseases?

- [✓ Yes]
- No

Would you like to answer questions about dementia?

- [✓ Yes]
- No

Would you like to answer questions about musculoskeletal conditions?

- [✓ Yes]
- No

Would you like to answer questions about cancer?

- [✓ Yes]
- No

Would you like to answer questions about mental health?

- [✓ Yes]
- No

Cardiovascular diseases

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels. It is one of the main causes of death and disability in the UK, and includes coronary heart disease, strokes, peripheral arterial disease, and aortic disease. Atrial fibrillation (an irregular, and sometimes fast heartbeat), high blood pressure, and high cholesterol are all risk factors for CVD. Evidence suggests taking action on these 3 risk factors will significantly reduce the number of strokes, heart attacks, and other types of CVD.

In your opinion, which of these areas would you like to see prioritised for CVD? (optional)

- 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
- Improving treatment provided by urgent and emergency care

- Improving non-urgent and long-term treatment and care to support the management of CVD

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)? (optional)

> We would like to leave this question to those with relevant personal experience, clinical and public health expertise and focus on the questions most relevant to social care provision.

Chronic respiratory diseases

Chronic respiratory diseases (CRDs) affect the airways and other structures of the lungs. Some of the most common are chronic obstructive pulmonary disease (COPD), asthma, occupational lung diseases and pulmonary hypertension. Respiratory diseases contribute to around 8,000 preventable deaths in the under 75s in England each year, and the UK has the highest prevalence of asthma in the world at around 9 to 10% of the adult population.

In your opinion, which of these areas would you like to see prioritised for CRD? (optional)

- 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
- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of CRD

Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. There are many different causes of dementia, and many different types. We recognise that dementia is a growing challenge. The number of people in England estimated to have dementia is set to rise to almost 900,000 in 2025 and to more than 1.3 million by 2040.

In your opinion, which of these areas would you like to see prioritised for dementia? (optional)

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

- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of dementia

Musculoskeletal conditions

Musculoskeletal conditions (MSK) affect the bones, joints, muscles, and spine, and are a common cause of severe long-term pain and physical disability. There are 3 groups of MSK conditions:

- conditions of MSK pain, for example, osteoarthritis and back pain
- inflammatory conditions, for example, rheumatoid arthritis
- osteoporosis and fragility fractures, for example, a fracture after a fall from standing height

Each year, 1 in 5 people in the UK consult a doctor about an MSK problem, and MSK is the leading cause of disability.

In your opinion, which of these areas would you like to see prioritised for MSK? (optional)

- 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)
- Getting more people diagnosed quicker
- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of MSK

Tackling the risk factors for ill health

The condition groups we are focusing on are often driven by preventable risk factors, with nearly half (42%) of ill health and early death being due to them. This includes tobacco, alcohol, physical activity, and diet-related risk factors. Action on preventable risk factors is also central to our work on tackling health disparities, since people living in more deprived areas are more likely to partake in these behaviours.

Do you have any suggestions on how we can support people to tackle these risk factors?

- [✓ Yes]
- No

How can we support people to tackle these risk factors?

You might consider suggestions on how we could:

- make changes at a local level to improve the food offer and support people to achieve or maintain a healthy weight and eat a healthy diet
- identify and support inactive people to be more physically active
- support people to quit smoking, including through increasing referrals to stop smoking support and uptake of tobacco dependency treatment
- support people who want to drink less alcohol to do so

Suggestions for tackling the risk factors for ill health. (optional)

> Disabled and older people who are in receipt of care or support services also face the risk factors that apply to the general population.
>
> Home based care and support services do not arrange catering or activity choices in the way that residential care providers might. Care and support services may be able to support people with either a) accessing healthy options that would not be available without support; b) might be able to sensitively suggest healthy options for a person’s consideration; or c) might be able to signpost people to other kinds of support, such as smoking cessation services.
>
> However, they will be limited by how they are commissioned and also by what the person they are supporting can afford in terms of food options. About 70% of homecare is commissioned by the public sector, and the rest purchased by the person receiving care or their families. The self-funders direct the support they want (or their families do, where the individual lacks mental capacity), and they would need to see the importance of encouraging healthy practices.
>
> Typically local authorities use time and task based commissioning, which may be one of the factors that limit care provider’s ability to deliver care that encourages healthy choices. With state funded homecare often what the social worker has prescribed in the care assessment is what has to be delivered.
>
> Stress on unpaid carers and loneliness for people living by themselves can also be significant risk factors for ill health. Having affordable, available care services that can also connect people to other kinds of support can help with both of these.
>
> Careworkers know the people they support well. Yet, home based care and support services are often not considered as partners when public health interventions are being considered.

Supporting those with conditions - supporting local areas to diagnose more people at an earlier stage

This part of the survey seeks to understand how we can improve outcomes for people with any of the major conditions, or a combination of them, across their life course. You do not need to respond for every condition - please just reply in the relevant box for where you have suggestions.

For these questions, we ask for you to consider the following in your responses:

- How we can improve outcomes for people across the life course, from pre-conception, early years, childhood and young adulthood, into adulthood and older age
- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity and geography
- What could be adopted and scaled quickly (that is, in the next 1 to 2 years) with impact
- What we can learn from local, national, and international examples of good practice, and what wider factors are either enabling them to be a success or are blocking them from being even more successful
- If you've tried a particular approach with success, please indicate the cost and be as specific as possible about how the approach was implemented

Supporting local areas to diagnose more people at an earlier stage

Do you have any suggestions on how we can better support local areas to diagnose more people at an earlier stage?

- [✓ Yes]
- No

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

You might consider suggestions to increase capacity available for diagnostic testing or identify people who need a diagnosis sooner.

Suggestions for multiple conditions (optional)

Careworkers are often the professional who spends the most time with someone: they know the people that they support well and can spot changes in their condition. This means that they can refer people for support early on. Careworkers are also required to keep records, which can be helpful in diagnosis.

At times health professionals don't recognise the skills or quality of relationship careworkers can have with the person that they support. It can also be challenging for care providers to know who to speak to when they notice changes in a persons condition. Added to this the longer waiting lists and a bigger backlog in diagnostic services since COVID have added pressure to the whole of the health system and can lead to difficulties with getting hold of GPs sometimes.

It would be helpful if careworkers could have direct access to specialist nurses (like Admiral nurses) or diagnostic services (e.g. memory clinics) to talk through issues when they are worried about someone.

Careworker training pathways could also be developed with the latest information on key signs to look out for that might indicate a person should be signposted for diagnosis. Easy to absorb updates (as our understanding of disease development changes) could be circulated to ensure the workforce remains aware of the latest knowledge. However, as we mention below, staff who must undergo higher levels of training would also need to have this reflected in better pay and terms and conditions, which would require additional funding to the sector as a whole (see our response to the next question).

Suggestions for CVD (optional)

Suggestions for chronic respiratory diseases (optional)

Suggestions for MSK (optional)

Suggestions for dementia (optional)

Supporting those with conditions - supporting and providing treatment for people after a diagnosis

Do you have any suggestions on how we can better support and provide treatment for people after a diagnosis?

- [✓ Yes]
- No

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 (optional)

Support groups, which are usually organised by the third sector, can be really helpful in enabling people to live-well with their conditions. Care staff are able to signpost people and their families to local support groups. However, what is available varies hugely across the country, this can feel like a postcode lottery.

Care staff who are more highly trained in understanding the specific conditions of the people that they support will be able to provide better care. The ability to specialise in major conditions or tackling and understanding risk factors should be considered as part of the care workforce pathway that is being developed.

Meaningful career progression for social care professionals should be combined with funding that would support pay increases that recognise the hard work and development that care staff undertake to maintain and develop their professional skills. This should be to a level that has parity with NHS staff.

Our Homecare Deficit Report and Minimum Price for Homecare illustrate that the rates that are paid by public sector commissioners are rarely enough to cover a basic pay offer let alone funding for reward and recognition of skilled staff. In 2021 only 14% of public sector commissioners in England (p.31) were paying at or above the rate we consider necessary to pay careworkers minimum wage. In 2023, in order to pay careworkers a rate of £11.85 per hour (equivalent to NHS Band 3 with 2+ years' experience) then care providers would need to be paid £28.44 per hour to cover careworkers oncosts, management, admin staff and the costs of running a business.

To pay careworkers higher rates to recognise additional training, then care providers would need fee rates that recognise this. Without funding to back it, many careworkers will not want to undertake specialised training.

Suggestions for CVD (optional)

Suggestions for chronic respiratory diseases (optional)

Suggestions for MSK (optional)

Access to physio and occupational therapy and timely access to the right equipment to support people to adapt to any MSK condition is vital. There can be delays and difficulties getting equipment when people come out of hospital. This is likely to require more significant action than the recently announced volunteer support in order to resolve, as it represents problems with internal communication issues within the NHS and not just workforce capacity issues.

It may produce better outcomes if careworkers have more direct access to allied health professionals and, where relevant, are seen as part of a multi-disciplinary team (MDTs) to support people. In some regions, for certain kinds of patient (e.g. complex hospital discharge), social care professionals are included in MDTs; but in other regions, on other occasions, social care professionals are not included in MDTs and may not be told the outcome of decisions made in MDT sessions, which can make it harder to provide support. In order to participate effectively in Multi-Disciplinary Teams it can be helpful to have one staff member from the social care team who leads on working with that particular person and knows what is happening for that person. They can then be the primary contact with the MDT.

Suggestions for dementia (optional)

Support for a person with dementia needs to be personalised. The type of support needed might depend on the type and severity of dementia, other health factors, mental capacity, physical function, pre-morbid personality and interests, the environment a person is in, social circumstances, cultural background, availability of family and so on.

People with dementia typically gradually lose their ability to hold conversations and discuss events, information or stimuli. This may hinder them from being able to voice their psychological needs. Caregivers of people with dementia may become primarily focused on addressing their physiological needs. This may leave the person with dementia with unmet psychological needs, resulting in agitated behaviours and poor psychological health outcomes, such as depression. It is not unusual for agitated behaviour to cease as soon as a psychological need is identified and met.

Changes in environment can be distressing and disorienting for people with dementia. People in their own homes can experience a higher quality of life and maintain more activities of daily living than those in residential care.

Maintaining calm and stable relationships with care workers can be fundamental to providing the best support for older people with dementia. However, the way that care is commissioned by local authorities with a focus on time and task may mean that inadequate time is given to manage complex communication with people being supported. Low fee rates being paid can also drive the use of zero hour contracts and a higher turnover in staffing, which can increase confusion for those receiving care.

Special consideration is needed for the support of younger adults with dementia and those who also have other conditions, for example Learning Disabilities.

It is helpful for social care staff to know the type of dementia that the person has been diagnosed with, but they are often not told.

Care workers need to understand:

- the different types of dementia and the way they may manifest and develop;
- how best to understand and meet a person's physiological and psychological needs, especially if verbal communication is not possible;
- how best to support people with memory loss and deal with the ethical dilemmas that arise, for example, whether to enter the person's reality or to refute their perception of reality, which may result in an intense emotional reaction;
- how to support a person who is experiencing agitation;
- the Mental Capacity Act and its implications, including how best to ensure safety whilst being mindful of deprivation of liberty safeguards.

Levels of knowledge about dementia among staff tend to be low when they first join if they have no prior experience. There is relatively little dementia training that is bespoke for homecare providers and affordable. The Homecare Association has developed a Train the trainer on dementia that we offer to our members at an affordable rate.

Education for family can be important if they don’t understand how dementia is affecting their loved one. This is not always available.

Supporting those with conditions - enabling health and social care teams to deliver person-centred and joined-up services

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

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 (optional)

There are significant issues accessing social services. A quarter of delayed discharges from hospital are due to people waiting for homecare, as there is a critical shortage of homecare workers. This hinders the ability of hospitals to admit new patients, contributing to increased ambulance response times and NHS waiting lists of over 7 million people. In the community, unmet need is high and rising. Councils still have waiting lists for assessments, direct payments and care services over 430,000. Over 1.6 million people need support with care at home and are unable to access it due to insufficient funding and workforce capacity. This needs to be addressed and will require additional funding, and would benefit from different approaches to commissioning and assessment.

It would be helpful for care staff to be able to interact directly with relevant health professionals to quickly resolve issues for the people that they support. For example, if care workers had access to dieticians or continence care nurses relating to the care of relevant individuals, this might help issues to be resolved in a timely and effective way.

Including care and support practitioners in Multi-Disciplinary Teams is key to enabling good communication and understanding of the person's situation. The fact that a care and support practitioner may have a good knowledge of the person's wishes, behaviour and any changes that they are experiencing might be invaluable in providing the right care. This relationship and knowledge is often not recognised. Care providers are not always included in MDT reviews at the moment, and may not have the outcomes of MDT meetings communicated to them.

Community healthcare professionals do not always understand what careworkers do, the boundaries of their role or how to get careworkers involved in different forms of care. They may, for example, have more experience in hospital settings and expect homecare staff to act in a way equivalent to Healthcare Assistants in Hospitals. Community nurses need to understand that tasks cannot be delegated to homecare staff just by instruction on site – discussions around delegation can take place with the care providers' service manager. Care providers may welcome taking on delegated healthcare tasks with proper discussion, but these will need to be accompanied by the appropriate training, sign off of competencies and funding.

Suggestions for CVD (optional)

Suggestions for chronic respiratory diseases (optional)

Suggestions for MSK (optional)

As mentioned earlier in our response, timely access to equipment, occupational therapy and physiotherapy is vital for people with MSK conditions. It would be helpful if social care professionals could communicate directly with the relevant allied health professionals about support for the people they are working with where necessary and relevant.

Suggestions for dementia (optional)

Sometimes care providers start supporting a person and only once supporting them do they realise that the person might have undiagnosed dementia. They might then need to help to signpost that person to diagnostic services.

As outlined above, it can be difficult to speak to the right person. It might be helpful if there were key contacts (such as personnel at the memory clinic or an Admiral nurse) who care providers can establish a relationship with and contact to make a referral or seek advice (with the appropriate consent of the person they are supporting/and or their family).

The need for joined up working to support people with dementia can extend beyond health and social care to other services such as housing. Some people with dementia will have specific issues with their vision and spatial awareness (depending on the type of dementia and how it develops). They may require some housing adaptations in order to ensure that they are safe and feel safe in their own homes. Housing providers and/or local authorities could work together with care providers on issues like this as needed. It would be helpful for these kinds of access needs and the role of care providers in providing support are well understood by housing providers.

Supporting those with conditions - use of research, data, and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions

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

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 (optional)

Remote health monitoring (for example, blood pressure checks) has been offered by some care providers. However, this may not be a sufficient solution if there is not matching capacity in the health service to respond to and interpret anomalous results.

Care providers, GPs and community nursing teams could usefully discuss opportunities for care staff to undertake some healthcare tasks, and assist with remote monitoring and digitally connect with healthcare teams, reducing the need for frequent health professional visits.

Care staff who are more highly trained in understanding the specific conditions of the people that they support, and could also be supported to undertake delegated healthcare tasks. Meaningful career progression for social care professionals should be combined with funding that would support pay increases that recognise the hard work and development that care staff undertake to maintain and develop their professional skills. This should be to a level that has parity with NHS staff.

If care providers are included in assessments they may be able to contribute knowledge of some of the digital technologies available to incorporate into the care and support plan for an individual. This might mean that people can live with a higher level of independence and sense of security. However, the technology has to be suitable for the specific needs of the individual.

Suggestions for CVD (optional)

Suggestions for chronic respiratory diseases (optional)

Suggestions for MSK (optional)

Suggestions for dementia (optional)

Safety of people with dementia may be a challenge in a home environment if they are inclined to wander or be unaware of hazards such as the need to switch off appliances. Technology can assist with improving safety, provided there are good surrounding support services.

Involvement of people affected by dementia and evidenced research in developing training pathways and role requirements is, in our view, patchy. Research evidence on care for people at home with dementia is not robust. Conducting research on care for people with dementia at home is challenging. Grant awarding bodies, such as NIHR, have demonstrated an intrinsic bias against homecare. Feedback on academic grant applications has included views such as “there is no point in funding homecare research because staff turnover is so high”. This is not universally true, though those in the private pay part of the sector tend to have greater stability and availability to participate in research, which needs to be counterbalanced.

We have been involved in a number of research initiatives around care and support for people with dementia. These included research around continence care for people with dementia and maintaining hydration, for example. However, getting the findings and recommendations out to the sector is not always done in a way that supports full implementation. Some of the research findings are behind pay walls. Full implementation would require support with the communication of best practice and incorporation of new findings into training (which all takes time).

Supporting those with conditions - improving access to palliative and end of life care

Do you have any suggestions of how we can improve access to palliative and end of life care?

- Yes
- No

How can we improve access to palliative and end of life care? (optional)

You might consider suggestions for how best to involve individuals in conversations about their future care.

Homecare staff, including careworkers need to have training to have confident conversations about end of life care plans with the individuals they are supporting. The Homecare Association provides end of life training. There could be more specialist, trained end of life care champions in the social care workforce. This could be incorporated into the proposed care workforce pathway.

Some care providers work with hospices to support end of life care expertise. However, there are not necessarily enough hospices with capacity to support all of the care providers involved in end of life care in people's own homes.

As mentioned earlier in our response, it's really important that care and support staff are seen as equal partners in Multi-Disciplinary Teams (MDTs). It can be helpful to have one staff member from the social care team who leads on working with that particular person and knows what is happening for that person who can also liaise with the MDT.

Hospice at home is a really important resource that could be done well in the future if developed intentionally with the right training and the outcomes for the individuals being supported at its heart.

Care staff working with end of life care may be in particular need of additional emotional and wellbeing support. Some care providers have looked into wellbeing support or employee assistance programmes for staff. Others have trained staff members as Mental Health First Aiders.

Cancer

The cancer call for evidence published in 2022 provided useful insights that will shape the development of the major conditions strategy. We have published what we heard in the cancer call for evidence, which can be found at the end of this survey.

However, if you wish to, we wanted to provide an opportunity to provide any further insights in this call for evidence.

How can we better support those with cancer?

You may wish to consider:

- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity, and geography
- How we can support those living with cancer and other conditions
- How we can better support local areas to diagnose more people at an earlier stage
- How we can better support and provide treatment for people after a diagnosis
- How we can better enable health and social care teams to deliver person-centred and joined-up services

Suggestions for better supporting those with cancer. (optional)

In one way there may be a problem with the way that the question is framed. Someone with advancing brain cancer may have completely different practical, emotional and personal challenges compared with someone with breast cancer or bowel cancer. The kinds of support that people need will be specific to their situation. A full range of flexible services are needed which put people’s specific circumstances first.

People may also have difficulty getting Personal Independence Payments or Continuing Healthcare (CHC) funding in a timely manner. This can be vital when they are struggling with sometimes rapidly escalating, potentially terminal, symptoms. Homecare providers can help to signpost people to sources of practical and financial support.

There can be delays with the delivery of equipment when people are discharged. Access to equipment suitable to the person’s needs in a timely manner is vital.

Mental health

The mental health call for evidence published in 2022 provided useful insights that will shape the development of the major conditions strategy. We have published what we heard in the mental health call for evidence which can be found at the end of this survey.

However, if you wish to, we wanted to provide an opportunity to provide any further insights in this call for evidence.

How can we better support those with mental ill health?

You may wish to consider:

- How we can target population groups most in need – including addressing disparities in health outcomes and experiences by gender, ethnicity, and geography
- How we can support those living with mental health and other conditions
- How we can better support local areas to diagnose more people at an earlier stage
- How we can better support and provide treatment for people after a diagnosis
- How we can better enable health and social care teams to deliver person-centred and joined-up service

Suggestions for better supporting those with mental ill health (optional)

There are significant issues at the moment with people being able to access the clinical support that they need, including appropriate crisis care. If there are limited services and long waiting lists social care providers may struggle to know where to signpost people for support.

It needs to be recognised that mental health conditions, such as anxiety and depression, can be experienced by people with other health conditions including dementia, autism and learning disabilities. The care and support available to these people may not always be suitably specialised. Social care teams may have a role to play in identifying when someone is experiencing mental health issues. There could be additional training for social care staff on this. However, there also needs to be the clinical services to refer people to.

Before you submit your response

We have a few questions we would like to ask to help us improve future calls for evidence and consultations.

How satisfied are you with the process? (optional)

- Very satisfied
- Satisfied
- [✓ Dissatisfied]

- Very dissatisfied

How did you hear about the call for evidence? (optional)

- Social media
- Word of mouth (family, friend or colleague)
- Broadcast news (TV or radio)
- Newspaper (online or print)
- Trade magazine
- Received an email
- Direct communication from third sector organisation or regulatory organisation
- [✓ GOV.UK or other government website]
- Website (non-government)
- Other

Do you think we could improve this process? (optional)

There are questions about whether this consultation is pitched at the right level.

On the one hand, there are concerns that a major conditions strategy will by necessity be very high level and combine groups of people with widely disparate needs.

On the other hand, support for people with these conditions is significantly limited by wider issues within the health and social care sector including funding deficits, narrowly defined time and task based commissioning practices and recruitment and retention issues.

Attention needs to be given to the big picture issues with the system and also the condition specific details of supporting people’s particular needs and circumstances.