

COVID-19 and Long Term Health Conditions: Interaction with Ethnicity and Migration

Recommendations

Participants' experience of managing long term health conditions during the COVID-19 pandemic suggests two concerns: an increase in long-term health conditions and poor health potentially yet to be fully uncovered by the NHS; and an over-stretched health and social care system. It is clear that changes are needed for a future fit for people with long-term health conditions. Emerging from their suggested changes, the strengths related by participants throughout the study, and the gaps highlighted in their support, we propose five priorities for discussion and development, with a common strand of "enablement" throughout. These priorities can be championed by residents of East London, health and social care professionals, community organisations and funders of the health and social care system, in different capacities and on many levels and modalities of practice.

Discover and connect to ways to step outside patient/professional roles.

- Identify and build own expertise in your own health.
- Build a community around expertise - champion peer support groups and public teaching resources.
- Encourage area-based health creation networks, including local people and organisations, to work towards shared goals to improve the potential of the local area for supporting health and wellbeing. Explore bringing further health services into the Primary Care Network geography to engender more local community-based relationships.
- Create community advisory roles for local people to work with health and social care systems, in particular around rebalancing power dynamics so that ethnicity, age and health condition are not used to dismiss people's experiences.

Contribute to navigating the system and connecting people with long-term health conditions to new opportunities.

- Fund roles which enable translation and interface with the health and social care system – such as care navigators, support workers, specialist social prescribers and advisors.
- Ensure these roles are available at the point of access to the systems and in particular for people who may have communication barriers, such as English as a second language.
- Find flexibility, connection and short cuts within referrals and system protocols through prioritising relationships between humans.
- Build collective support – create fora sharing what works to navigate the system.
- Increase access to digital skills support, ESOL classes and translators, forming communities of learning and empowerment.

Connect discussions about mental and physical health.

- Identify own energy demands and limits.
- Begin gentle discussions with friends, family and neighbours about mental health and connect with others who are doing the same.
- Share resources and tools for psycho-education, in a variety of community languages, including ways to build wellbeing and to understand mental health.
- Make space for collective recovery from the pandemic – providing opportunities for sharing grief, memorials, death cafes, public discussions about mental health.
- Increase availability of longer-term therapeutic relationships with professionals and peer supporters, such as through talking therapies and local mental health organisations.

Involve a wider group of people in finding innovative, practical solutions to day-to-day living for people with long-term health conditions.

- Explore new models of flexible carers and volunteer responders for regular, practical tasks. Invite the voluntary sector and school networks to participate.
- Train carers and support workers to use person-centred approaches.
- Explore a fast track response system for social care assessments.
- Prioritise opportunities to connect communities and enable emotional support, such as respite, befriending or day trips for unpaid carers.

Integrate opportunities to anticipate and prevent common needs within the health and social care system.

- Redirect some of the bottlenecks in points of access into the system – particularly the need for a GP appointment or a social care assessment to unlock support.
- Anticipate common social needs for each health condition – for example, welfare benefits, emotional support, appropriate exercise – as a standard part of regular health condition reviews, such as through linking with social prescribing teams.
- Partner with local VCS to provide health-supporting activities and groups. Explore models of micro-commissioning for activities involving cohorts of patients where there is a gap in provision– such as for complementary therapies, or adjusted exercise classes.
- Communicate waiting times, delays and cancellations promptly and regularly.
- Ensure the system provides a “safety net” – introduce an access line to direct people in need of information.
- Invest in capacity for the NHS to meet routine appointments and provide more face-to-face support.

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