Reducing Inequalities Alliance

Inclusion health & LTCs

Key themes from the needs assessment

March 2025

Polly Masson

Key points from Long Term Conditions and Multimorbidity: A needs assessment from a health inequalities perspective

Definitions

A **long term condition** is one that generally lasts a year or longer and impacts on a person's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental health conditions and stroke. Long term conditions may also be known as 'chronic conditions'[1]. They cannot be cured but can be manged and controlled with medication and/or other therapies.

Multimorbidity refers to the co-existence of two or more long-term health conditions**,** which can include:

- A physical non-communicable disease of long duration, such as diabetes, cardiovascular disease, or cancer.
- A mental health condition of long duration, such as a mood disorder, schizophrenia, or dementia.
- An infectious disease of long duration, such as HIV or hepatitis C.

Additional health conditions that commonly contribute to multimorbidity include:

- Ongoing conditions, such as learning disability.
- Symptom complexes, such as frailty or chronic pain.
- Sensory impairment, such as sight or hearing loss.
- Alcohol or substance misuse.

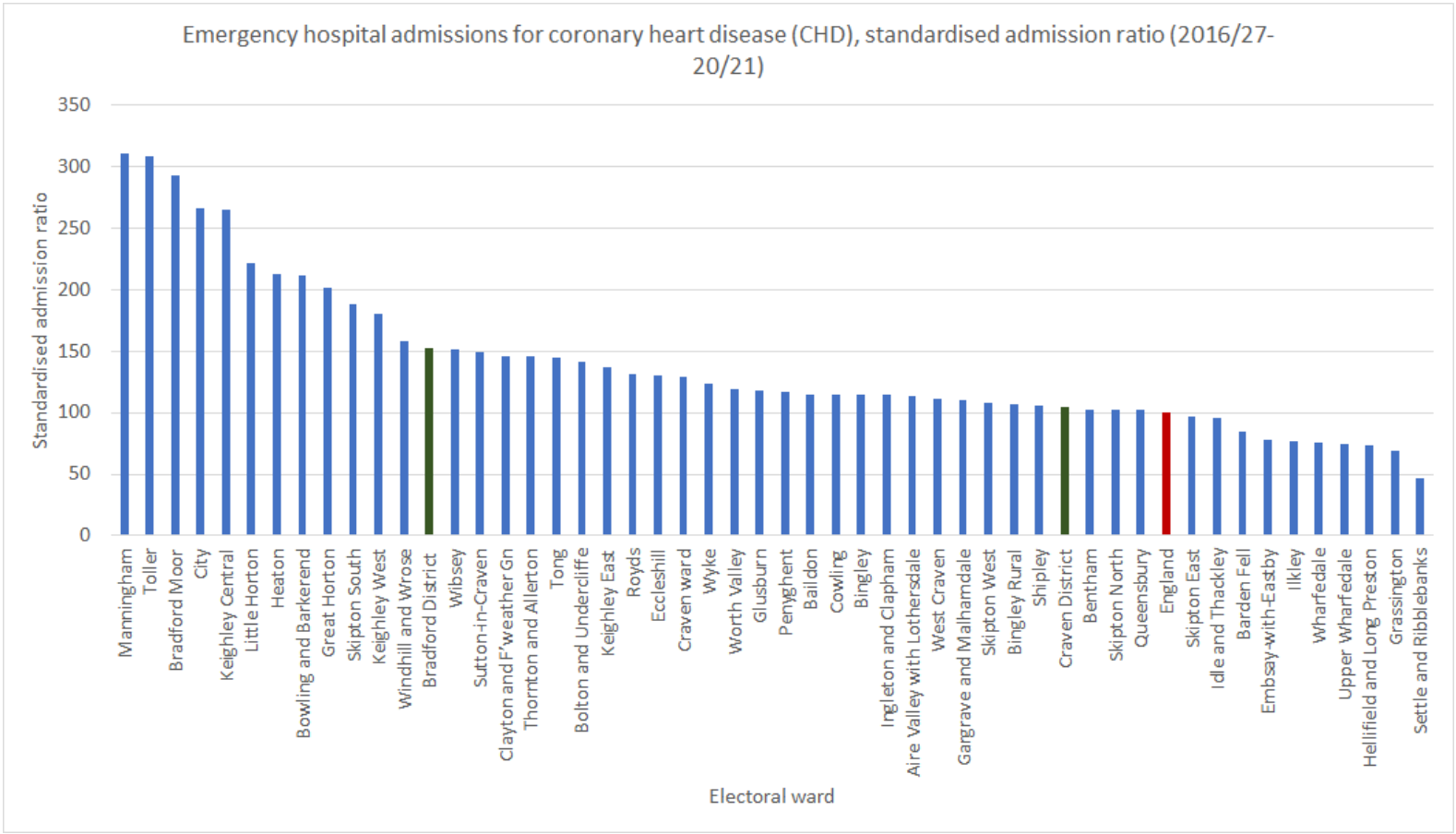
Multimorbidity is also referred to as 'multiple long-term conditions', which is often the preferred nomenclature in patient groups[2].

1. Context | Older people with social care needs and multiple long-term conditions | Guidance | NICE
2. Definition | Background information | Multimorbidity | CKS | NICE

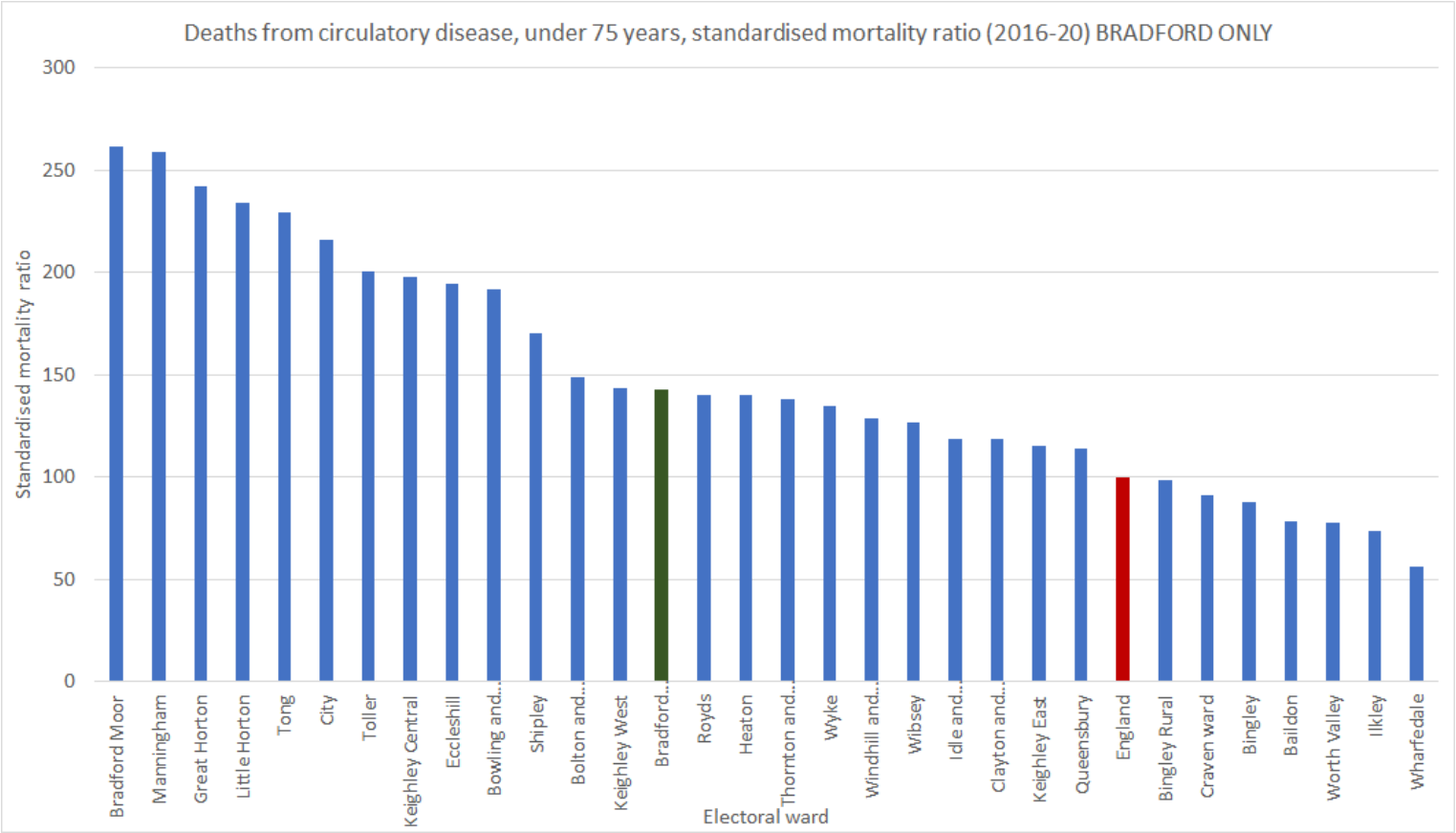
Key points from the needs assessment: 1

- Number of people with long term conditions, and multiple long term conditions are increasing. Our local primary care data show that most conditions are on an increasing trajectory.
- They contribute to lower mortality and life expectancy rates and are also a contributing factor in the lower healthy life expectancy rates.
- Circulatory (CVD), cancer and respiratory disease account for over half of the life expectancy gap for males and females in both Bradford District and North Yorkshire.
- With this comes increasing health and social care needs and economic inactivity.

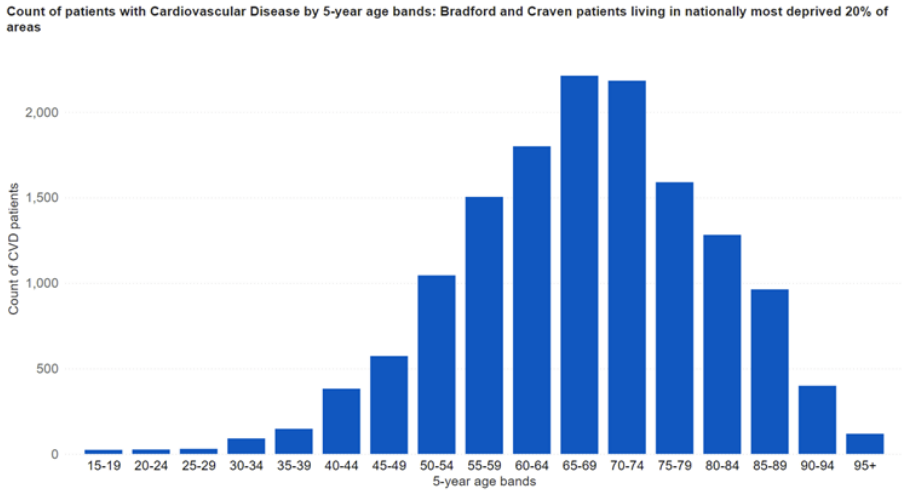
Emergency admissions for coronary heart disease

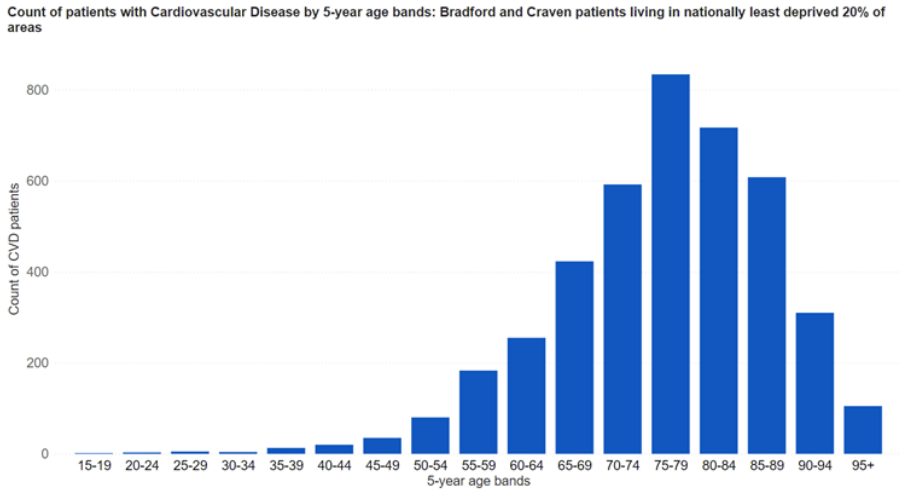


Deaths from circulatory disease, under 75 years



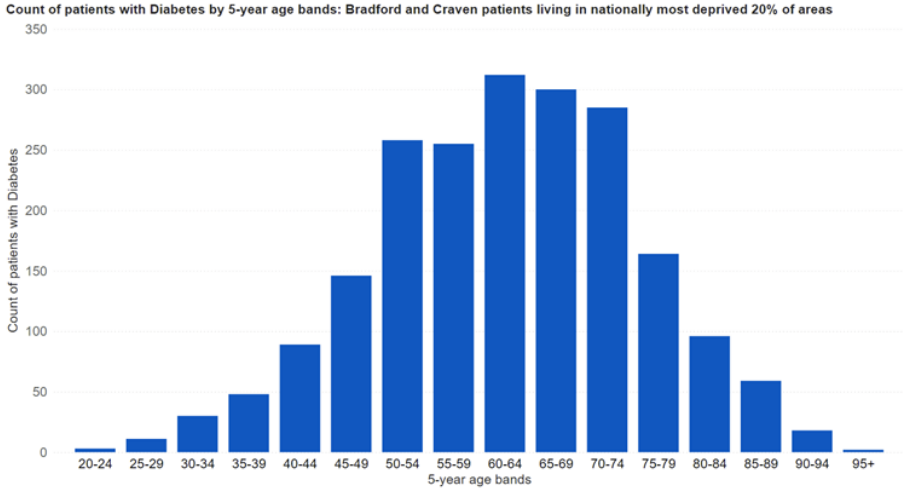
Distribution of CVD by age, comparing least and most deprived areas

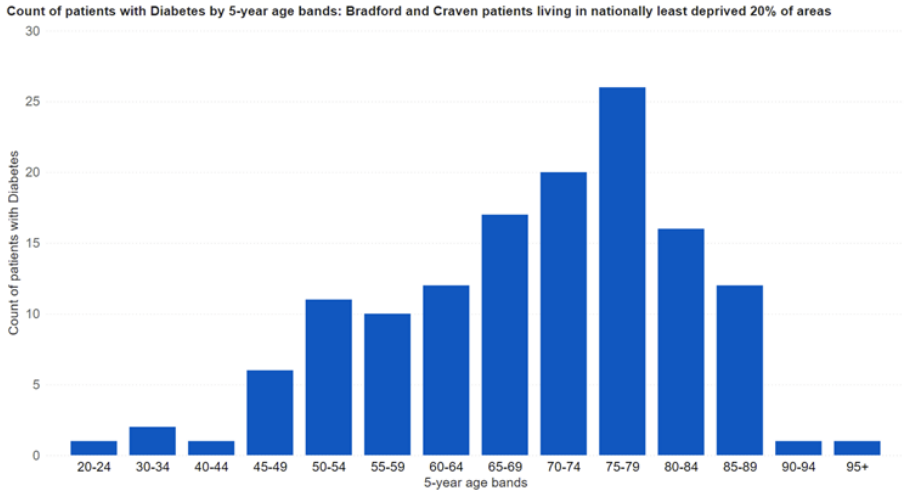




These histograms compare the ages of people with CVD in the most deprived areas with the ages of those in the most deprived areas. We can see that the most frequently recorded age value is younger in the most deprived deciles.

Distribution of diabetes by age, comparing least and most deprived areas





These histograms compare the ages of people with diabetes in the most deprived areas with the ages of those in the most deprived areas. We can see that the most frequently recorded age value is younger in the most deprived deciles.

Key points from the needs assessment: 2

- The development of long term conditions occurs at a younger age in our most deprived areas, starting when people are in their 20s.
- The difference between most and least deprived communities is starkest for people in their 40s. We need to take action to delay or prevent disease progression at this point
- Long term conditions, by their nature, have the potential to be managed, delayed and in some circumstances prevented, if appropriate action is taken at the right time.
- The evidence of the effectiveness of primary and secondary prevention interventions is clear. We need to understand the root causes of variation in uptake and delivery of services and then take action to reduce this variation

Multimorbidity

Key points from the needs assessment

- The incidence of multimorbidity is also increasing. However, the distribution of people with multimorbidity across our population is not equal. The population within our most deprived areas experience multimorbidity at a much younger age.
- The median age of people with three or more long term conditions varies between 49 (central Bradford) and 82 (Ilkley). The median age of people with three or more long term conditions is under 65 in 40% of areas (LSOAs) in Bradford District and Craven.
- The overlap of depression and musculoskeletal conditions with cardiovascular disease and chronic respiratory disease is significant. We need to change our pathways to recognise this and move away from condition specific silos

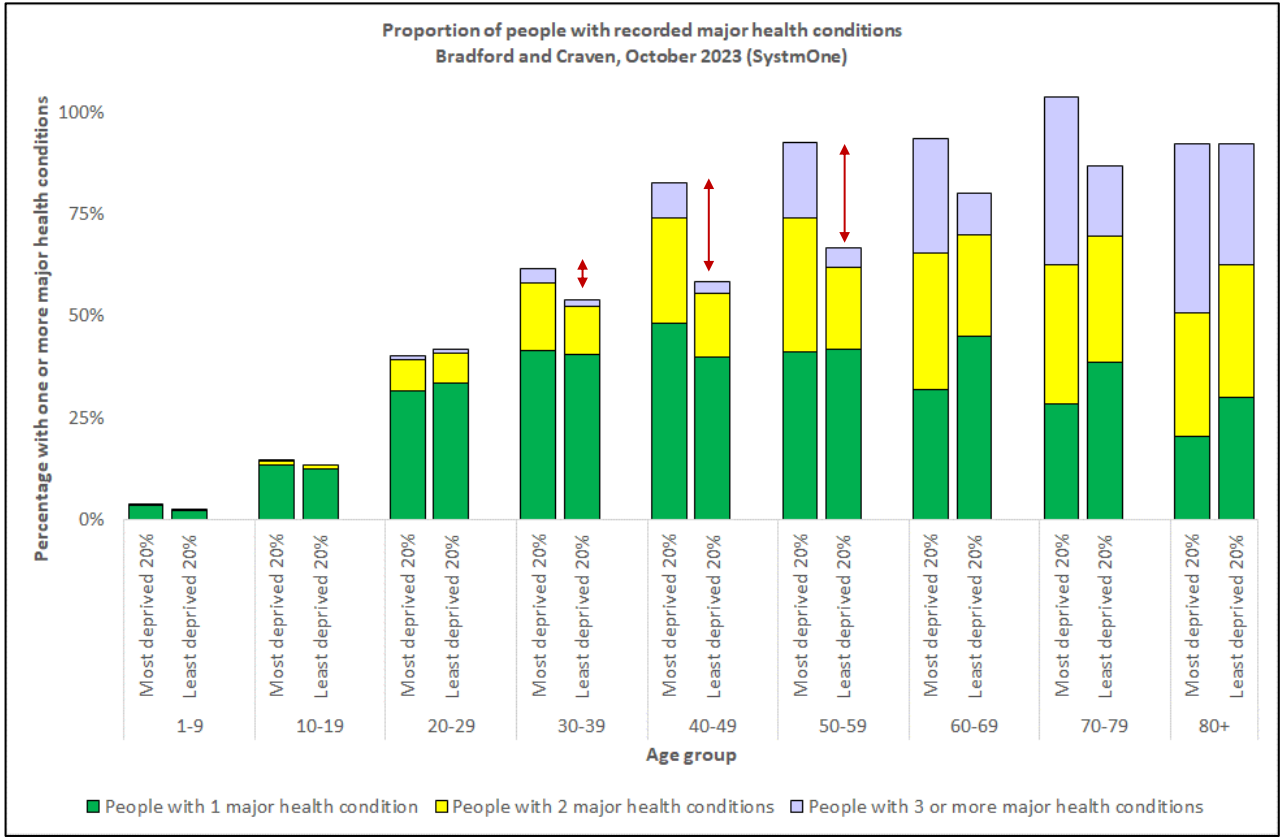
Proportion of people with multiple conditions

People with 3+ major health conditions		
	Most deprived 20% of areas	Least deprived 20% of areas
Age 40-49	1 in 11	1 in 33
Age 50-59	1 in 6	1 in 20
Age 60-69	1 in 4	1 in 10
Age 70-79	1 in 2	1 in 6

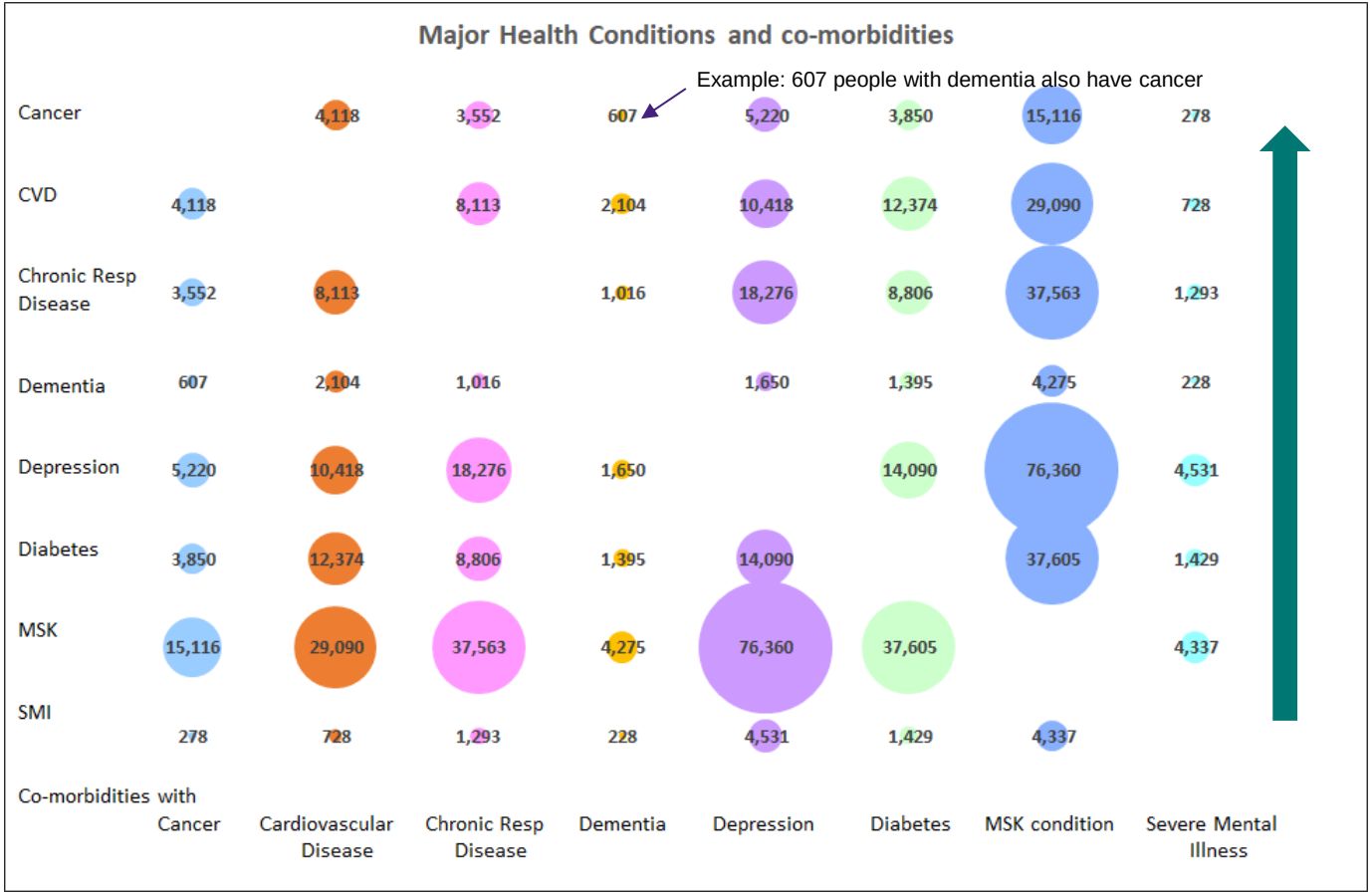
The deprivation impact on multi-morbidity is highest for 40-70 years.

The likelihood of having 3 or more major health conditions is higher for someone aged 50-59 in the most deprived 20% of areas (18%) than for someone aged 70-79 in the least deprived 20% of areas (17%).

This is a key age to maximise impact of screening programmes



Key multi-morbidity pairings: numbers



Key co-morbidity groupings **<u>in terms of numbers</u>**

MSK with all other conditions (due to high numbers with MSK)

Depression with CVD, diabetes & chronic respiratory disease

Bradford and Craven patients with diagnosis recorded in primary care (October 2023)

Intersectionality

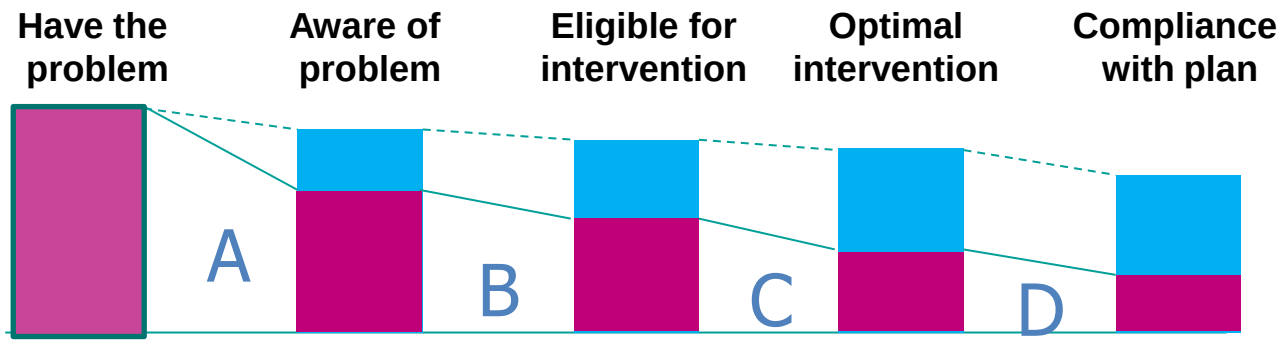
1. **Socioeconomic Disparities:** Deprived areas often have higher rates of chronic health conditions due to limited access to healthcare, unhealthy living conditions, and lifestyle factors. As a result, individuals in these areas are more likely to experience multimorbidity.
2. **Delayed Diagnosis and Treatment:** People in deprived areas may face barriers to early diagnosis and treatment of chronic conditions. Delayed diagnosis can lead to the progression of these conditions, making them more challenging to manage.
3. **Limited Access to Care:** Deprived communities may have fewer healthcare resources, including primary care providers and specialists. This limited access can hinder the effective management of multiple conditions.
4. **Psychosocial Factors:** Multimorbidity can be exacerbated by psychosocial factors such as stress, poverty, and social isolation, which are often more prevalent in deprived areas.
5. **Health Behaviour Patterns:** Deprived populations may have higher rates of risk behaviours like smoking, poor nutrition, and physical inactivity, which increase the likelihood of developing multiple chronic conditions.

A framework for action

Framework: Intervention decay model

- The intervention decay model is a simple framework developed by Professor Chris Bentley
- Aims to illustrate how a range of factors can influence an individual's ability to achieve the best health outcomes.
- Considers inequalities across a care pathway, showing how various determinants can contribute to creating healthcare inequalities
- It is a useful framework for LTCs, as these conditions have the potential to be managed, delayed and in some circumstances prevented, if appropriate action is taken at the right time.

Components of ‘Intervention Decay’

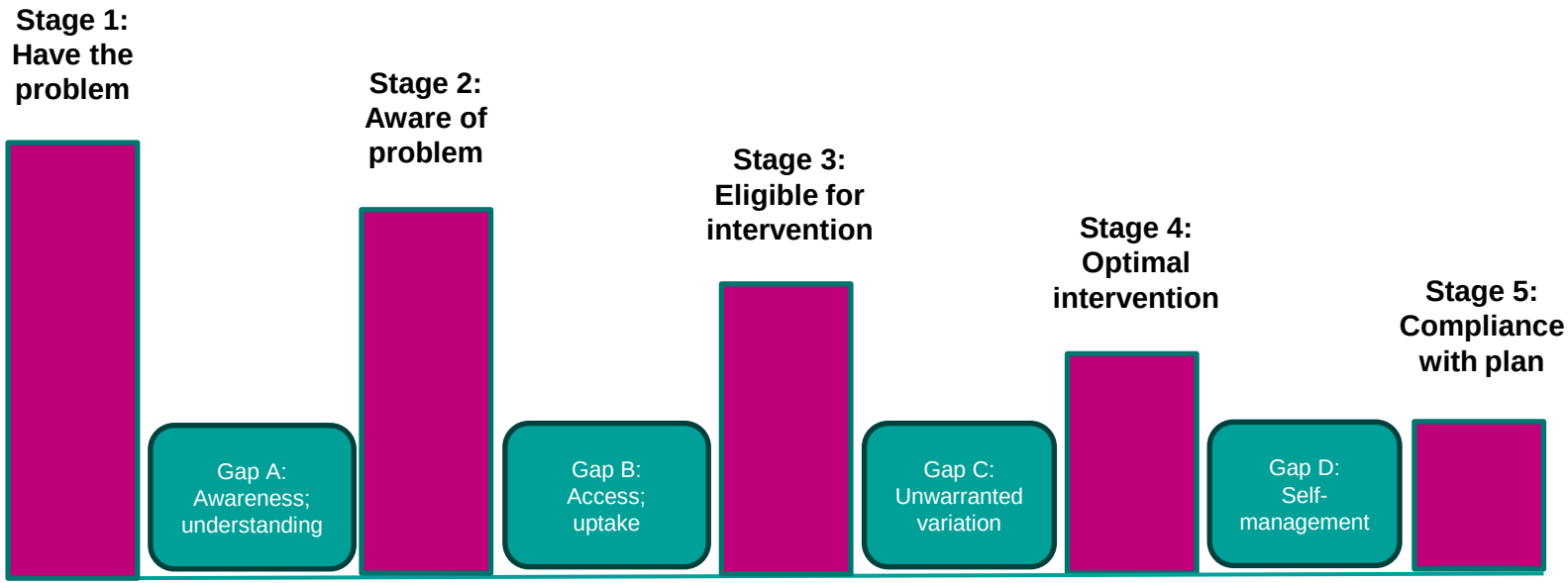


Least deprived population quintile (20%)

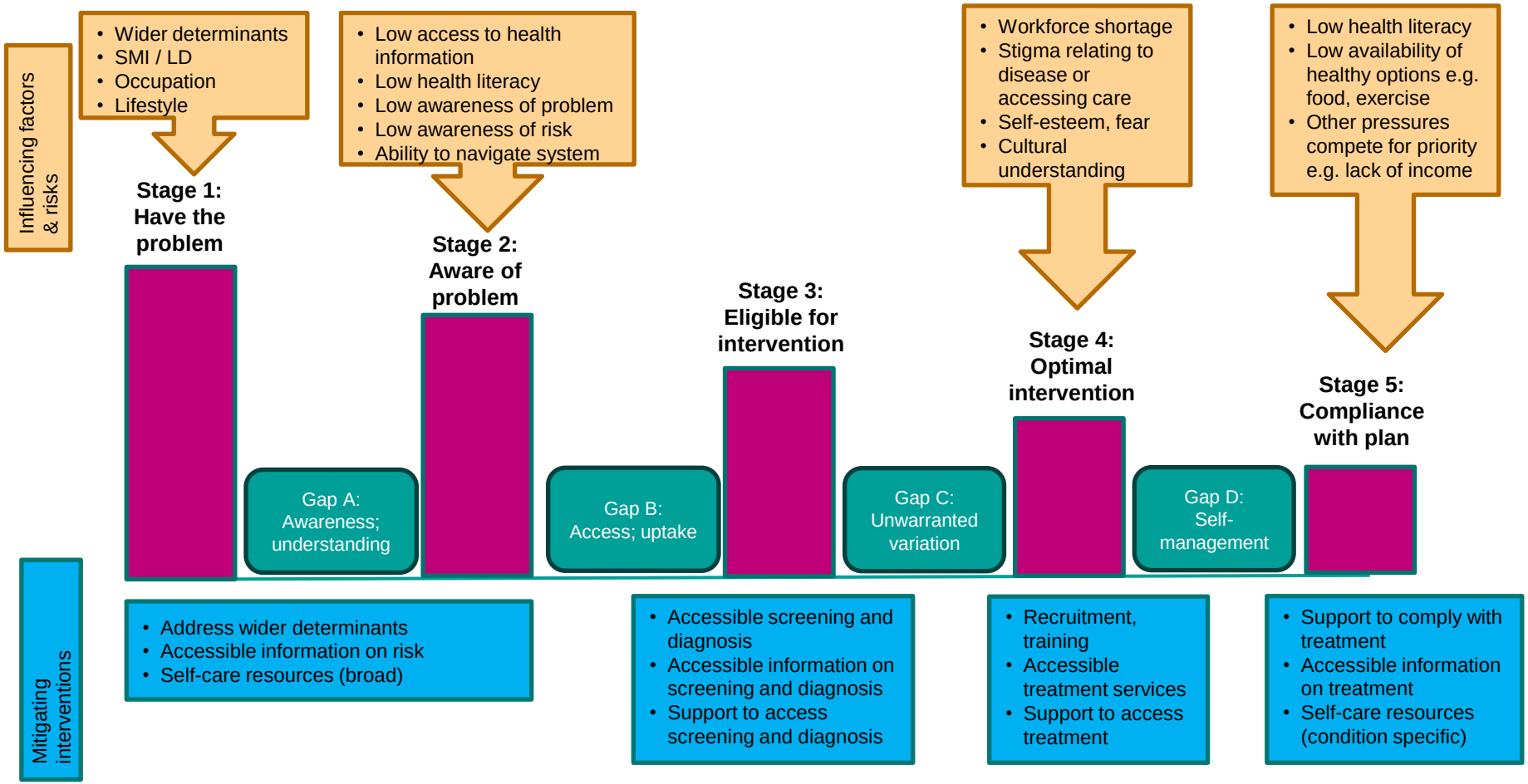
Most deprived population quintile (20%)

Bentley 2019

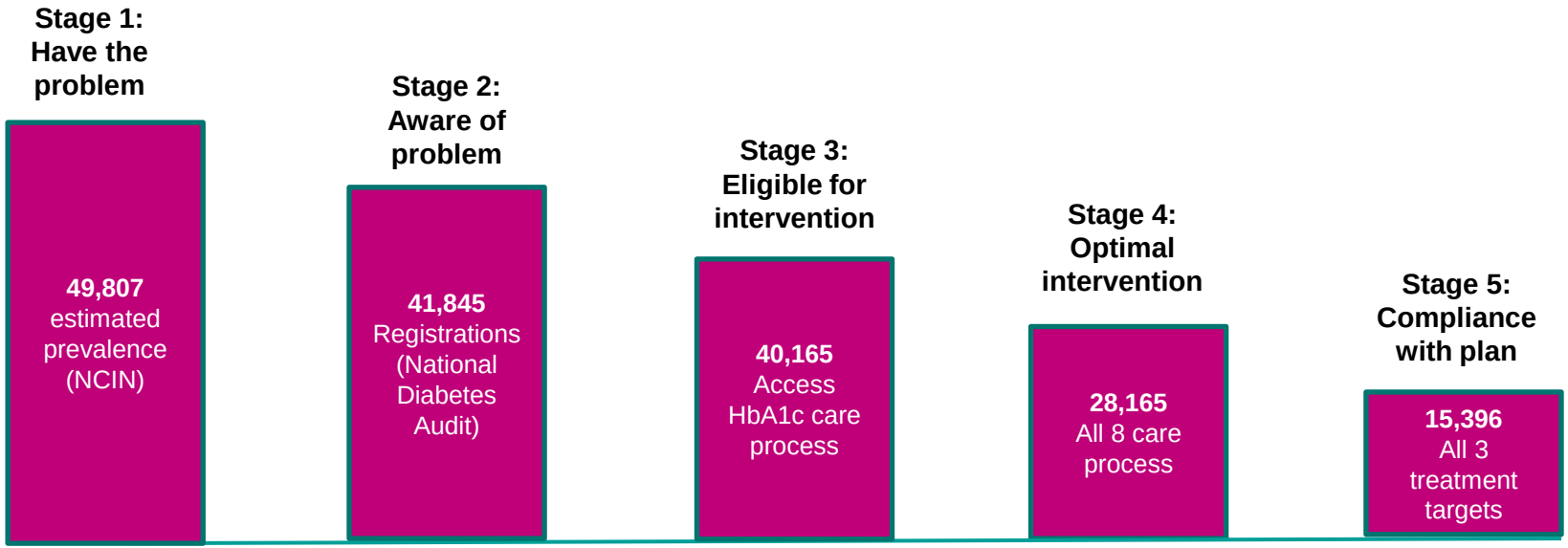
Intervention decay model - 1



Intervention decay model - 2



Intervention decay model - 3



Key points

- To support people to take greater control over their health, increase treatment adherence and opportunities for effective self-management, we need to understand and recognise the impact of the wider determinants of health. These are extensive, and include:
  - Health literacy and the ability to find, understand and use health information
  - Community awareness of symptoms and support offers
  - Employment and ability to attend appointments when choice and flexibility is not offered
  - Poverty and ability to travel to appointments
- Taking action to reduce inequalities in long term conditions is not only the right thing to do from a moral perspective, but also necessary from a financial perspective. Unnecessary costs linked to health inequalities can arise in the NHS for a variety of reasons, such as:
  - Poor treatment outcomes due to poor adherence (impact of financial and literacy challenges)
  - Missed appointments due to working patterns or transport availability
  - Emergency admissions through a lack of preventative care
  - Inappropriate service usage, for example A&E attendance for minor ailments
  - Exacerbation of conditions due to poor living standards

Thank you

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Bradford District and Craven Health and Care Partnership

ACTasONE

Community based NHS health checks

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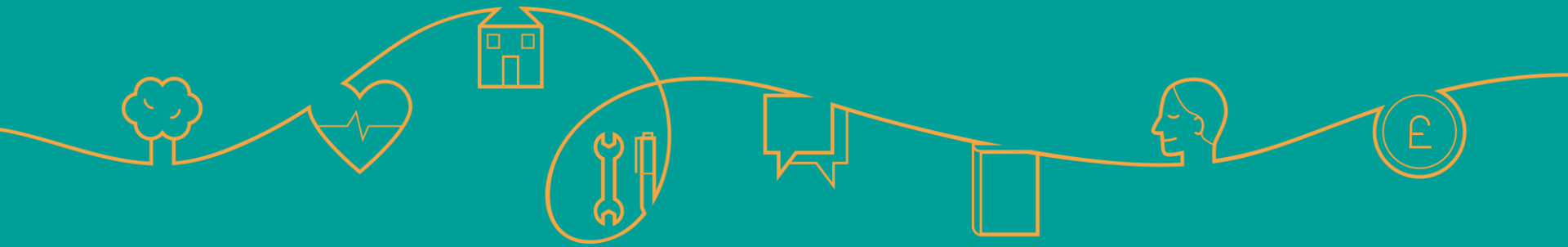
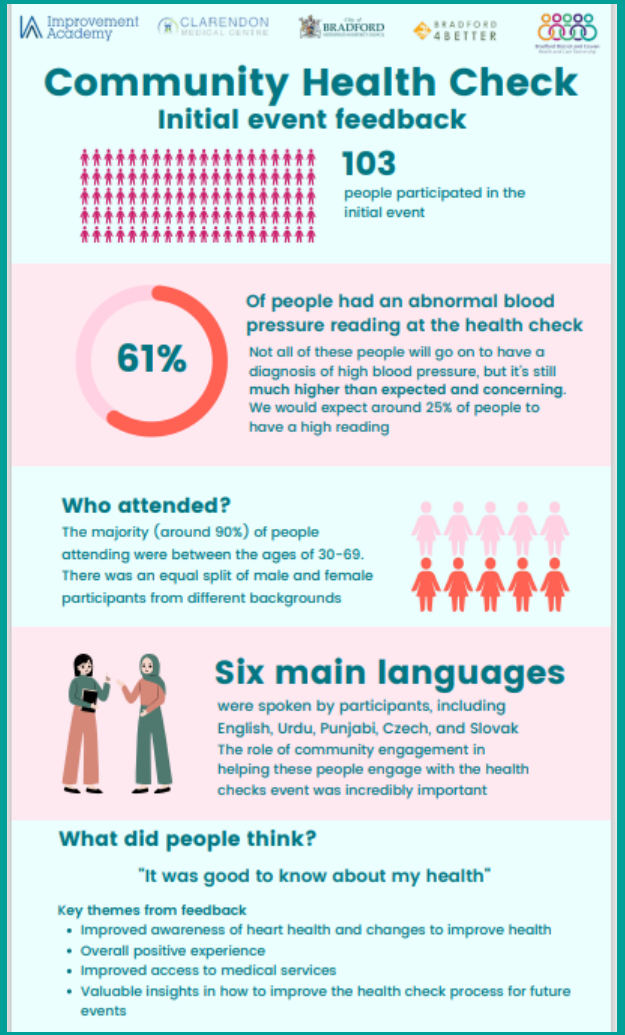


NHS health checks – how it started:

- Unmet need in hypertension annual reviews post covid. More than 50K people in Bradford District and Craven HCP had not had BP check
- Covid had prevented NHS health checks to be offered and so backlog of 40 -74-year-olds had not been offered a health check.
- Health inequalities data showed in the poorest areas with highest levels of deprivation cardiovascular disease and diabetes remained two of leading causes of premature death in Bradford District and Craven
- Healthy Hearts and Improvement Academy collaboration to test the art of the possible

NIHR Applied Research Collaboration – Improvement Academy development phase



Core20 and project to pathway

Consistency and guidance

Reducing Inequalities Alliance

Community health checks PCN/GP/ Community partnerships guidance

Section	Page number
1. Introduction to community health checks	
2. Getting started: preparing for a community health check event	
3. Delivery: carrying out a community health check event	
4. Follow up: ensuring the intervention is effective	
Appendices 1. NHS health check guidance 2. Communication template 3. Skills and training for health check staff 4. Marketing materials 5. Equipment and costings, protocol for Snomed code 6. Risk assessment template	

1. Community health check model

Why?

- Unmet need in hypertension annual reviews post covid. More than 50,000 people in Bradford District and Craven HCP have not had BP check.
- High levels of unplanned hospital admissions for CVD related illness in inner-city Bradford
- Covid has prevented NHS health checks to be offered and so backlog of 40-74-year-olds have not been offered an NHS health check.
- Health inequalities data shows in the most deprived areas cardiovascular disease and diabetes remained two of leading causes of premature death in Bradford District and Craven.
- 27% of the gap in life expectancy for men and 23% of the gap for women between most and least deprived populations in Bradford is due to cardiovascular disease (2020/21).

What constitutes a community health check?

- A community health check is an NHS health check completed with the support of a community partner in a central community-based location.
- The health check must include the following to classify as a community health check:
- Recording of:
  - age
  - gender
  - smoking status
  - family history of coronary heart disease
  - ethnicity
  - body mass index (BMI)
  - cholesterol level
  - blood pressure
  - physical activity level
  - alcohol use disorders identification test (AUDIT) score
  - cardiovascular risk score, those aged 65-74 should be made aware of the signs and symptoms of dementia and signposted to memory services if this is appropriate.

See **Appendix 1** for NHS health check guidance.

How far can we reach?

- Delivery of health checks in the community and in particular NHS compliant health checks has increased significantly in the last year.
- To date the programme has delivered 45 health check events in the community and conducted a total of 893 checks of which 521 were NHS compliant.
- A further 900+ people have attended events for information on the health and wellbeing.
- Of the checks undertaken –
  - 424 people have been identified as having a health risk
  - 291 people have been identified as having raised blood pressure.
  - 336 people have been referred to other services including GPs for follow up.

Opportunities in inclusion health groups

- New venues and target cohorts using new VCS partners
- Well-developed model that can be lifted into many community venues
- Reaching communities with bespoke model around a consistent core offer
- Learning from recent smaller events on extent of reach to include education on screening, Living well and wider initiatives
- Learning for Public health future commissioning plans

References

- Community-health-check-guidance-July-2024-for-website-accessible-no-appendices-002.pdf
- NHS Health Check - National guidance
- Health Checks event infographic

Thank you
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Reducing Inequalities Alliance - Bradford District & Craven Health & Care Partnership (bdcpartnership.co.uk

Bradford District and Craven
Health and Care Partnership

ACTasONE

Cardiovascular Health in people experiencing homelessness and substance misuse

Dr Eleanor Wilman and Dr Andy Lephard

Bevan CBS

National picture – pathway report 2024 - Always at the Bottom of the Pile: The Homeless and Inclusion Health Barometer 2024 – Pathway

Average age of death for homeless people 46 for men and 42 for women

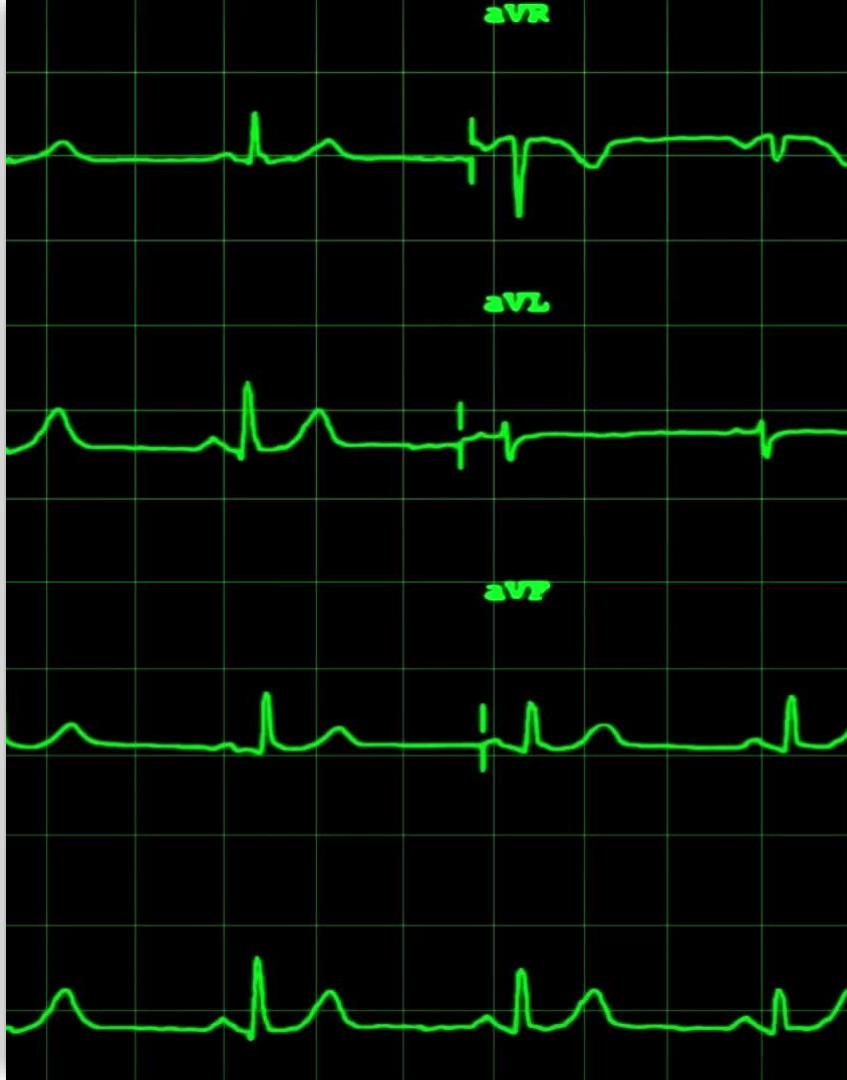
Tri-morbidity - complex combinations of physical health, mental health and substance misuse.

people experiencing homelessness often live with multiple long-term conditions and experience levels of frailty normally associated with the elderly

Locally – longterm conditions and cardiovascular disease

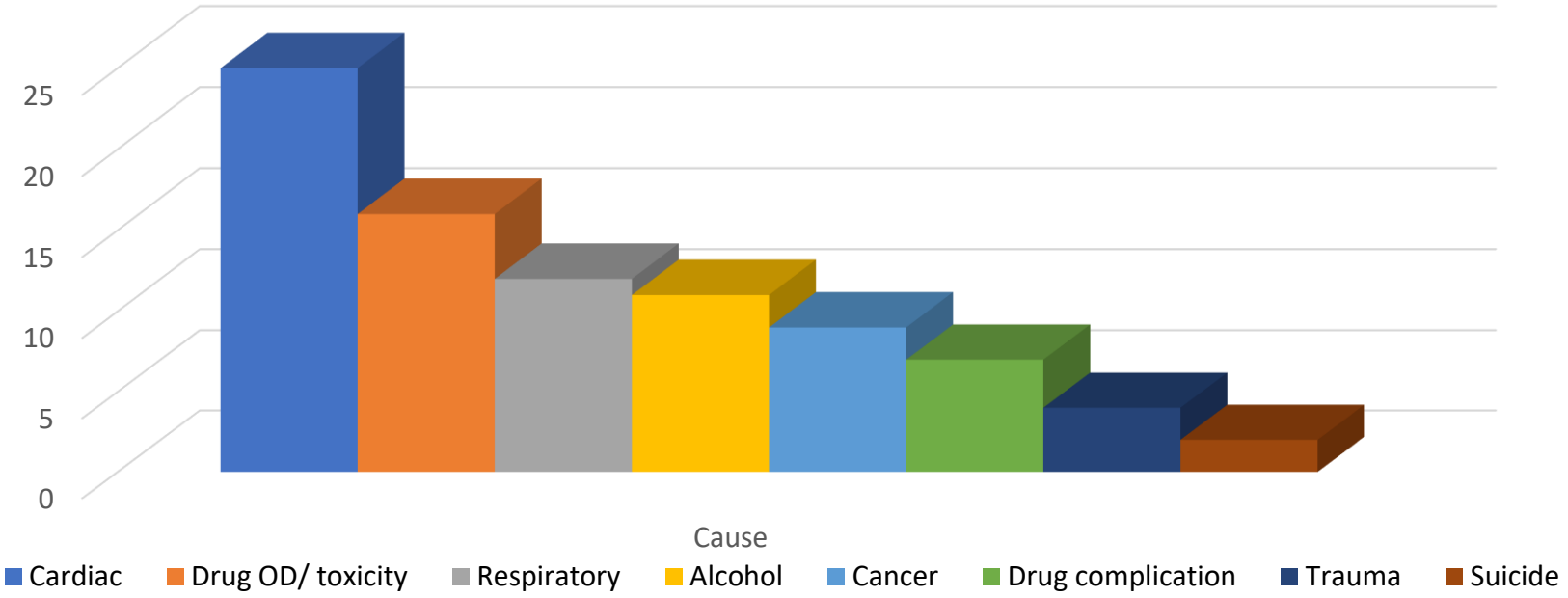
- Bevan Bradford patients on substance misuse register
  - 938 patients
  - Predominantly aged 35-55 (min 18, max 81)

    46 (5%) have established diagnosis of heart disease
  - 125 (13%) have established CVD, diabetes or hypertension
  - 72 (8%) are on hypertension register. 30 with last BP >150/90
  - 153 (16%) with last BP >150/90 without hypertension diagnosis



Causes of death*

*multiple causes of death identified in individual patients



Locally – deaths in Bradford and Leeds

- 15-25 deaths per year across both practices
- Average age similar to national picture
- Highly skewed towards homeless population rather tha vulnerable migrants
- Always some cardiovascular deaths including heart atta strokes – striking considering young population
- Better data in Leeds due to communication from coron – some deaths due to heart disease we wouldn't have

What is needed?

Screening

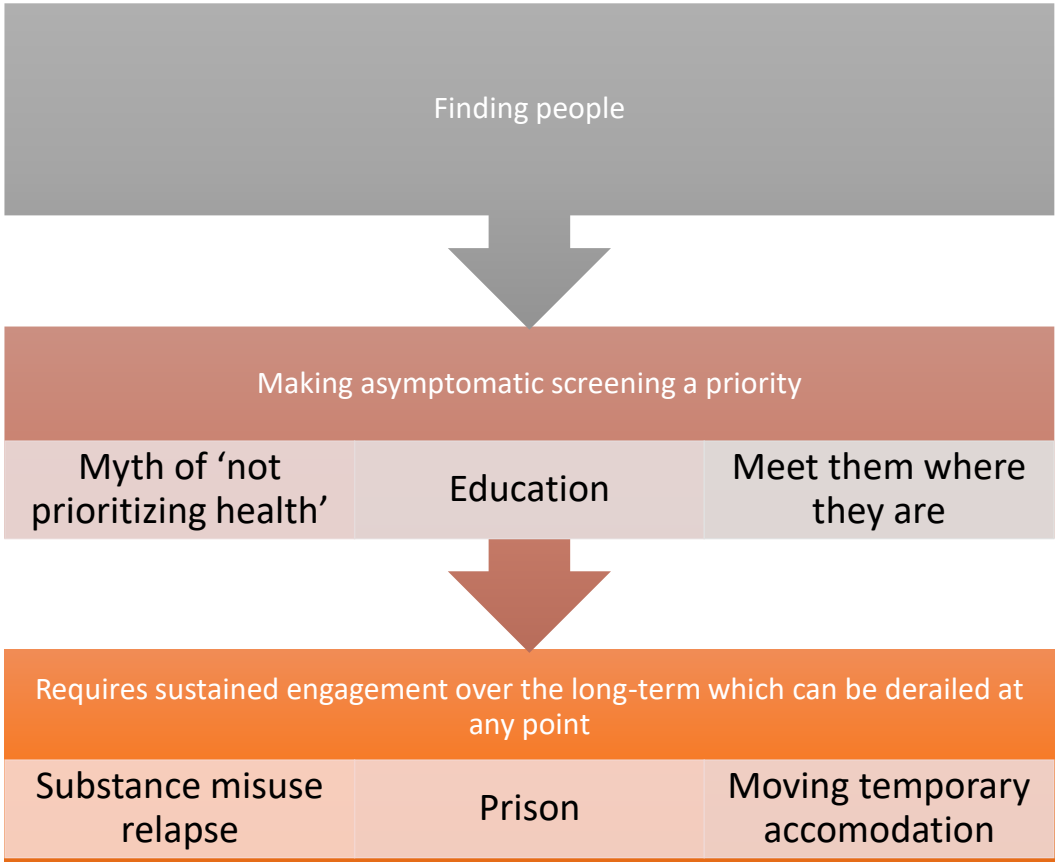
- Identify early – at risk younger in t group

Treat and optimise treatment

- Needs sustained engagement

Keep going with treatment

What are the barriers?



What works

- Hypertension example
  - Patient on methadone with high blood pressure but reluctant to take medication
  - Trauma informed approach – serial consultation with doctor and nurse alongside methadone prescribing
  - Pharmacist dispensed blood pressure medication daily alongside methadone
  - Blood pressure came back to normal range

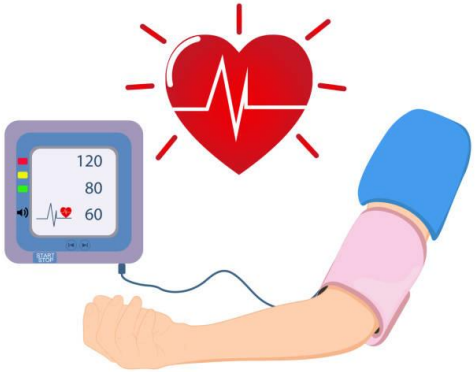
What works?

- Cardiovascular disease review
  - 71y patient with previous MI and stroke
  - Not been taking any medication for long time
  - CV review with GP booked but DNA
  - Phone review attempt 1: put the phone down
  - Phone review attempt 2: refused to confirm details, complaining about abuse from the health service, very angry.
  - Phone review attempt 3: Engaged with discussion. Restarted 2 medications. Agreed to speak with wellbeing team

What works?

- Chronic lung disease example
  - Patient at risk due to smoking heroin and crack and had described symptoms
  - Outreach nurse, multiple interactions laying groundwork for screening
  - Multiple failed attempts to catch her with outreach bus
  - Eventually spent 4 hours working with her, diagnosis made and treatment started

Know Your Numbers and How to take a Blood Pressure



Health and Wellbeing Academy
University of Huddersfield

West Yorkshire
Health and Care Partnership

Adapted by David Armitage. Originally developed by University of Huddersfield nursing students

Guidance training not formal clinical training.
Audience:BP champions.

Objectives

- **Understand what Blood Pressure is.**
- **Understand how to take a Blood Pressure using an automated machine.**
- **Understand the blood pressure thresholds in non-clinical settings.**
- **Learn some Top Tips to prevent errors.**
- **Provide some practical experience of taking Blood Pressure.**
- **Introduce the NHS BP online tool.**

What Numbers Do You Need To Know?

We believe every adult in the UK should know their blood pressure numbers in the same way they know their height and weight.

Knowing your numbers means that you can take steps to lead a longer and healthier life.

120/80

An normal pressure is between 90/60 and 120/80mmHg. Do you Know Your Numbers?

6 million

6 million people in the UK have high blood pressure and don't know it.

350

Every day in the UK, 350 people have a stroke or heart attack that could have been prevented.

Know Your Numbers!

Blood Pressure UK

All about Blood Pressure

1. What Is Blood Pressure?

Blood pressure is the pressure at which our heart pumps blood through our circulatory system.

Blood pressure is measured using two numbers, the top is systolic, and the bottom is diastolic.

2. What Is a Normal Blood Pressure?

A normal blood pressure is usually between 90/60mmHg and 120/80mmHg

3. What Are Systolic and Diastolic Blood Pressure?

The top number (systolic) measures the pressure in your arteries when your heart beats.

The bottom number (diastolic) measures the pressure in your arteries

Blood pressure test - NHS (www.nhs.uk)

All about Blood Pressure

4. What Health Problems Are Associated With High Blood Pressure?

Heart disease, heart attack, stroke, kidney disease.

LOW Blood Pressure?

Nausea, dizziness/light-headedness, fatigue and risk of falls.

5. What Is the Treatment for High/Low Blood Pressure?

HIGH Blood Pressure: lifestyle changes such as eating healthily and exercise to maintain a healthy weight, reduce salt intake, stop/reduce smoking. Medication may be required depending on the severity.

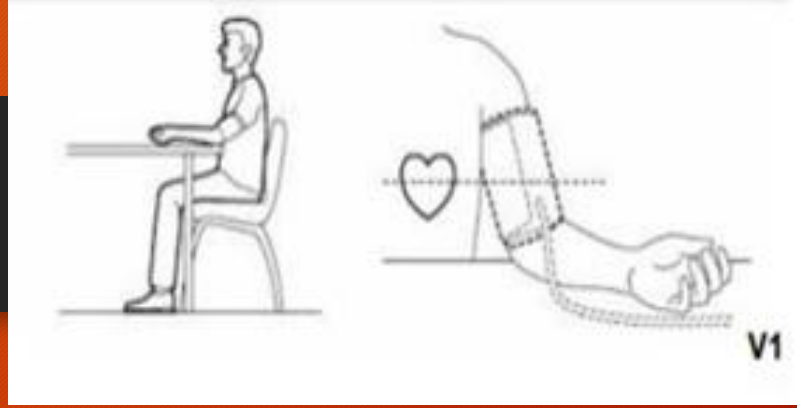
LOW Blood Pressure: stay hydrated, limit alcohol consumption. Medication may be required depending on the severity.

If further info needed: Blood pressure test - NHS (www.nhs.uk)

Before taking a Blood Pressure Reading

- Explain who you are.
- Is the person feeling well enough? If not advise to reschedule.
- Enquire if they know what their blood pressure normally is and whether they are under treatment if outside normal ranges.
- Ask simple question about the persons day, this will help relax them.
- Allow a few minutes rest before taking the blood pressure.
- Ask which arm the person would prefer.
- Warn the person the cuff will squeeze their arm for a short time.

How to take a Blood Pressure Using an Electronic Device



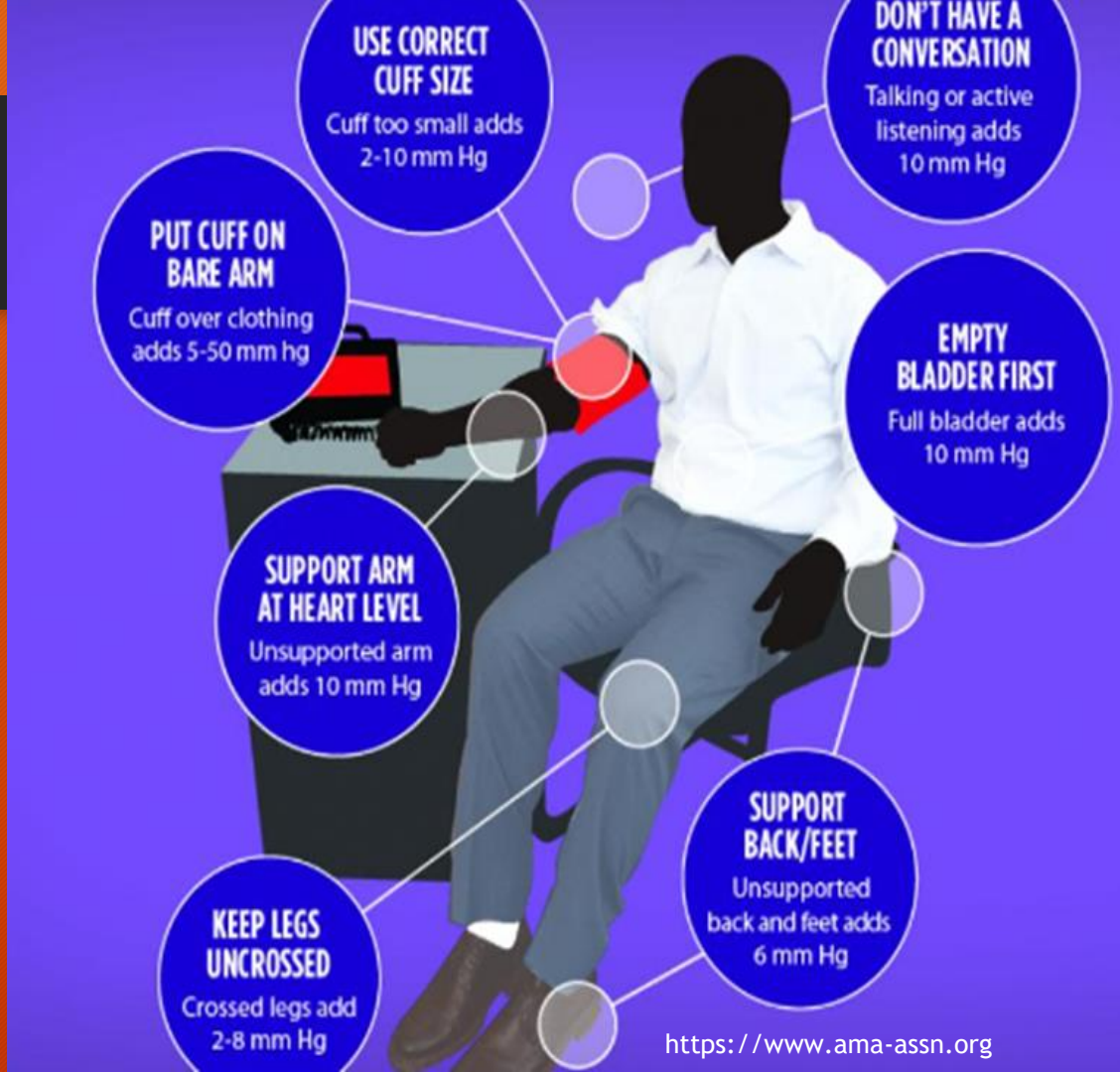
- Position the cuff on the upper arm, a couple of centimetres above the elbow.
- Follow the positioning instructions on the cuff.
- The cuff should be tightened over your arm with the cuff wire leading freely to the monitor.
- Keep still and quiet when the reading is being taken. Talking or moving may affect the reading.
- Record Blood Pressure up to 3 times, with at least 1 minute between each reading.
- Record and share the lowest reading. It is common for readings to be different.

Cuff Sizes

- Standard Adult - 12 x 26 cm if arm circumference is between 23 and 33 cm
- Large Adult - 12 x 40 cm if arm circumference is between 33 and 50 cm

Top Tips for taking a Blood Pressure Reading

- Avoid Stimulants prior (e.g coffee)
- Avoid taking in non-clinical setting if patient doesn't feel well/Ask well?
- Ask if patient know's / has had BP check before
- Support arm at heart level
- Right size cuff/ put cuff on bare arm
- Check comfortable and doesn't need toilet.
- Don't have a conversation during
- Repeat BP (especially if out of range)
- Be prepared for an anxious response to BP result.
- If BP low (below 90 systolic) Dizzy?



Blood Pressure Protocol

Normal BP

90/60 - 120/80

Recheck within 5 years.

Raised Blood Pressu

121/81 to 134/84

Take steps-lifestyle, exercise.Recheck1mt

(Enter Your Reading - Check Your Blood Pressure - NHS, 2023) https://www.nhs.uk/health-assessment-tools/check-your-blood-pressure-reading

Blood Pressure Protocol (non clinical readings)

High BP

Systolic above 134, diastolic above 85Aged 80+ 145/85 is classed as High BP

Go to GP or Pharmacy within 2 days

Very High BP

Systolic 169 or Above

Urgent GP/111

Low BP

NHS Checker doesn't allow systolic under 70 Diastolic under 60 = low BP

Recheck within a year if no symptoms

*Low BP – if you're having symptoms, recheck your blood pressure every month or as often as GP advice.

https://www.nhs.uk/conditions/high-blood-pressure-hypertension/

See GP or dial 111 if symptoms. **Be**

Quiz Time - Multiple Choice

1. What is an ideal blood pressure?

a) 145/90

b) 120/80

c) 100/55

2. What could affect a blood pressure reading?

a) Wrong cuff size

b) Moving and Talking

c) Dehydration

d) All the above

3. What should be avoiding before having a blood pressure reading taken?

a) Drinking water

b) Caffeine

c) Relaxing

4. What can constantly high blood pressure cause?

a) Heart attack & Stroke

b) Tiredness

c) Tremors

d) High Blood Sugar

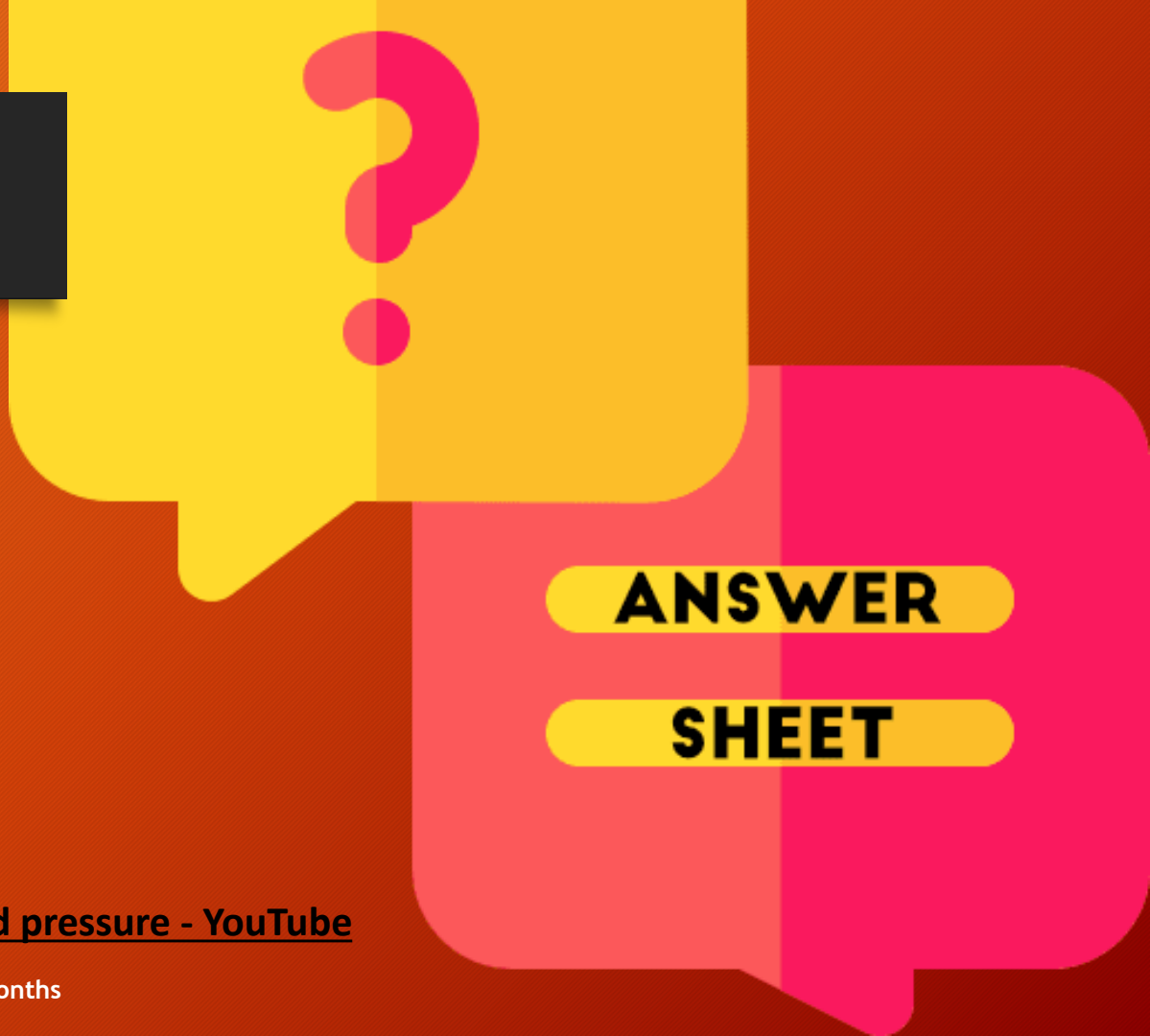
Quiz Time - Multiple Choice

5. Why is the correct cuff size important?
a) Don't want someone to feel uncomfortable
b) Could cause incorrect reading if wrong size
c) Incorrect cuff size could lead to misleading advice
d) All the above

6. What can you do to help control high blood pressure?
a) Nothing
b) Drink more alcohol
c) Exercise regularly

Quiz Time - Answers

1. B
2. D
3. B
4. A
5. D
6. C

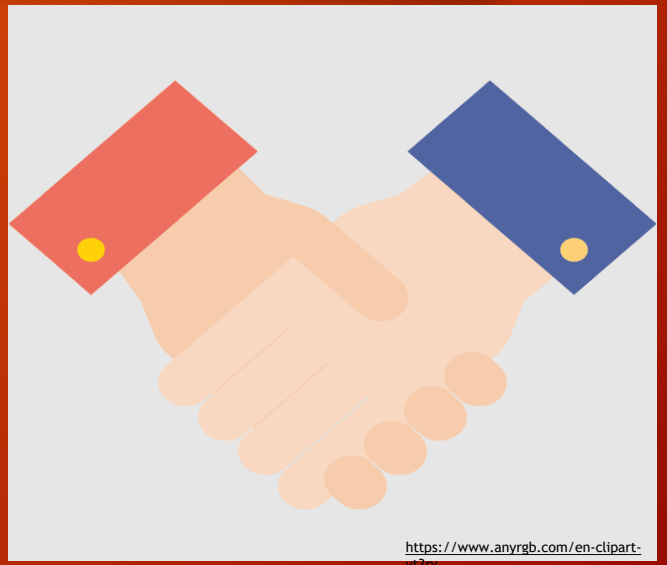


WATCH How to take someone's blood pressure - YouTube

*Please refresh training to include Q&A's every 12 months

Helpful Information and Links

- https://www.nhs.uk/health-assessment-tools/check-your-blood-pressure-reading
- Blood Pressure UK
- Manage your blood pressure at home - BHF
- Overview | Hypertension in adults: diagnosis and management | Guidance | NICE
- https://www.nhs.uk/conditions/high-blood-pressure-hypertension/



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