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Reducing Health Inequalities in Local Communities in South West London

September 2020

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What is a Long term condition (LTC)? 1/2

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- A **long-term condition** is an illness that usually cannot be cured
- Symptoms and complications can usually be controlled with treatment.
- Examples are;
  - **Cardiovascular disease**
  - **Muscular & skeletal**
  - **Respiratory**
  - **Diabetes**
- Research suggests that the people who do best are those who take responsibility for managing their own long-term condition in partnership with their doctors.

What is a Long term condition (LTC)? 2/2

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- Long-term conditions are more prevalent in;
  - **Older people**: 58% of people over 60yrs compared to 14% under 40yrs
  - **More deprived groups**: Those in the poorest social class have 60% higher prevalence than those in the richest social class
- **Far reaching implications** - Can effect peoples roles within their family, their job, their accommodation, their education and there finances
- Mental health, specifically **depression** and **anxiety** are 2 – 3 times more likely to affect a person with a long term condition
- The mechanisms underlying the relationship between mental and physical health are **complex**, and evidence suggests that a combination of **biological, psychosocial, environmental and behavioural factors** may all be involved

Diabetes

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- Type 1 and Type 2 (main types)
- No longer manage the amount of sugar in the blood and the sugar cannot enter the cells to provide the cells/body with the energy it needs
- Someone is diagnosed every 2 minutes
- 4.8M in UK (reaching 5.3M by 2025) approx. 1M don’t realise they have it!
- Risk factors for Type 2 diabetes;
  - Non modifiable (genetics, ethnicity, age,)
  - Modifiable (weight, lifestyle)

Cardiovascular Diseases (CVD)

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- ❖Umbrella name for conditions that affect your heart and circulation
- ❖Conditions include coronary heart disease (CHD), high blood pressure and stroke
- ❖7.4 million people live with CVD in the UK, causing 27% of all deaths
- ❖This equates to 167,000 deaths per year or 460 people every day, of which 44,000 premature (British Heart Foundation; July 2020)
- ❖Around 80% of people with CVD have at least one other health condition
- ❖Symptoms include chest pain, breathlessness, dizziness, very fast or slow heartbeat
- ❖Risk factors include smoking, stress, alcohol, being overweight or obese, Diabetes, high blood pressure, being physically inactive, family background, age and ethnicity. Some are modifiable, others are non modifiable
- ❖Evidence shows that If you're South Asian, African, or African Caribbean, your risk of developing some heart and circulatory diseases can be higher than for white Europeans

Risk Factors by Ethnicity

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Black Caribbean/Black African

- Almost twice as likely to have a stroke than white people
- More likely to have high blood pressure and diabetes
- In the last 20 years, stroke incidence in London has decreased by 40% for white people, but has not decreased for Black Caribbean people

South Asian

- On average, people of South Asian descent in the UK have strokes 10 years earlier than white people
- South Asian people are almost twice as likely to develop diabetes (a risk factor for stroke) as the rest of the UK population, and are likely to develop it at an earlier age

What is the problem?

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- BAME communities tend to suffer from higher rates of comorbidities, including hypertension and diabetes
- Our community-led health clinics pilot project in Wandsworth highlighted this increased risk for BAME groups of developing Type 2 Diabetes, CVD conditions and obesity, with high detection rates for both Type 2 Diabetes and CVD conditions
- BAME communities are often overrepresented in acute and emergency care and underrepresented in preventative and early intervention services highlighting the need for bespoke and co-produced intervention programmes
- The recent Public Health England publication on disparities in the risk and outcomes from COVID-19 shows that people from a BAME background are disproportionally impacted, highlighting the existing and exacerbated health inequalities that they are facing, with poorer access to health and care services
- Greater consideration must also be applied to the wider determinants of health, such as housing and employment and cultural and social barriers, as 80% of someone's physical and mental health is determined by these factors
- Our work with local community partners in Wandsworth, but also in other areas in South West London, evidences the lack of trust and confidence that BAME communities have in mainstream services. Many of the current services are not culturally sensitive or adapted to their needs, resulting in a low uptake of prevention and early intervention support

What did we do?

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Context

- The Health Innovation Network funded a LTCs Detection pilot project in community centres and places of worship targeting underrepresented (BAME) communities (£10k); additional funding received from Wandsworth CCG and SWL Diabetes programme
- Co-produced and co-led with Wandsworth Community Empowerment Network (WCEN), local community and faith leaders and members, Public Health, British Heart Foundation and Diabetes UK
- Delivered across 6 places of worship in Wandsworth, developing networks and community integration between statutory services and local communities
- NHSE personalised care funded training of 25 'community champions' to be health coaches/link workers. 2 now work for the NHS
- Community champions and volunteers worked across all sites, despite differences in ethnicity or faith, meeting cultural and religious expectations
- Identified opportunities for local interventions and new culturally adapted delivery routes

- 322 people responded to the question, ***'What or who motivated you to attend this Community-led Health Clinic?'***
  - 36% (117 people): *'My Community/Faith Leader'*
  - 13% (42 people): *'I want to know if I am well'*
- 291 people responded to the question, ***'How would you rate the location of the clinic today?'***
  - 97% (281 people): *'Very satisfied'* or *'Quite satisfied'*

Community-Led Health Clinics

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Aims and Objectives

- To reduce health inequalities
- To empower and upskill local communities
- To detect unknown risks and raise awareness of risks and importance health checks, e.g. through faith leader promotional films
- To co-produce care pathways
- To increase trust and confidence between local communities and statutory services
- To increase GP registrations
- To create a peer network of community champions / health coaches / faith leaders
- To spread and adopt the model across South West London

Key Outcomes/Benefits

- 1,000 health checks carried out
- Reduced number of attendances and admissions in primary and secondary care
- Increased awareness of Long-Term Conditions
- Signposted people at risk to further support in local health and care services improving access
- Increased confidence and trust of local communities in statutory services, e.g. NHS
- Decreased number of people without a GP
- Improved patient experience of health checks
- Identified further upskilling, health and care needs and opportunities for interventions

Review of Data

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441 Participants of health clinics

60% High or Moderate risk of getting Type 2 Diabetes

25% Possible Hypertension; 1.6% severe hypertension

3.4% Possible AF (N15)

4 High Heart Rate and 1 Low Heart Rate

5% Suspected COPD (N7)

Impressions of Community-Led Health Clinics Project

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What can we do?

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- Our new project in Merton and Wandsworth expands on the health clinics project and aims to address the inequalities that are faced by local (BAME) communities through:

- **Investment in Communities** – Recruitment of ‘activity and communications coordinators’ to assist different community and faith partners

- **Capacity and Capability Building** – Upskilling of local community champions to become health coaches through an accredited curriculum. In addition to this community and faith leaders will be upskilled further through a peer to peer mentoring system together with system leaders. Aim is to establish an enhanced community workforce, enabled to respond to crises and coproducing new ways of working to address inequalities

- **Prevention Decathlon** - We will deliver a remote and culturally adapted health intervention programme called ‘Decathlon’. Decathlon was piloted in Merton and exceeded expectations. It will be expanded with Cardiovascular Conditions and is a combination of education and physical exercise which can also be linked to the SWL LTC toolkit. Health and wellbeing resources and educational videos/audio will be co-produced and culturally adapted reducing people’s risks of getting LTCs and inequalities

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Long-Term Condition Toolkit

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Long term conditions toolkit website

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Help to keep our *LTC patients safe from Covid-19

- Covid-19 information: both general and condition specific
- Helplines: local, national, and condition specific

Help to keep our *LTC patients healthy and well whilst 'staying at home' or 'shielding' during the social distancing period (help prevent disease deterioration)

- Condition specific and general information
  - Emotional Support
  - Lifestyle: Eating, Moving, Wellness
  - Health
  - Medical

*ALL LTC patients including those who English is a second language

The 4 Long term conditions in the toolkit

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Cardiovascular disease

- High blood pressure (hypertension),
- Stroke
- Heart failure
- Atrial fibrillation
- Peripheral vascular disease (PAD or PVD)

Respiratory

- Asthma
- COPD

Diabetes

- Type 1
- Type 2 diabetes

Muscular & skeletal

- Arthritis
- Chronic pain

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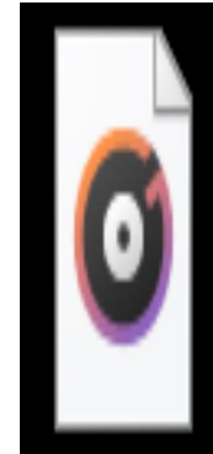
https://www.swlondon.nhs.uk/ourwork/long-term-conditions/

Examples – Easy Read Documents and Audio



Exercise diabetes UK.m4a

Discussion

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What would be of interest to you, your family and/or your community about this type of programme? Or, is there anything that might prevent you from taking part?	Have you got any ideas about how this programme or any other similar things could be supporting to people you know?	Is there anything that the service or people in the community could do, to reach/help those who would really benefit from help to manage/stay well if they have a long- term condition