The Taskforce on Multiple Conditions Digital events series: Multiple conditions and health equity

May to July 2021

Contents

In this pack you'll find…

Introduction

From 11 May to 6 July 2021, The Taskforce on Multiple Conditions worked with Kaleidoscope Health and Care to run a series of digital events to raise awareness of – and explore solutions to tackle – the issues at the **intersections between Multiple Long Term Conditions** (MLTCs) and **health equity**.

These 'learn and share' events were designed to explore how primary care networks (**PCNs),** alongside **local government, NHS** and **third sector organisations** can work together to design solutions to support people living with multiple conditions.

We hope in sharing this event write up, key stakeholders will be enabled to **reflect on the learning** within local networks and **share insights and further opportunities** that will help the Richmond Group to identify areas for **future focus**.

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Multiple Conditions and health equity: what were the events?
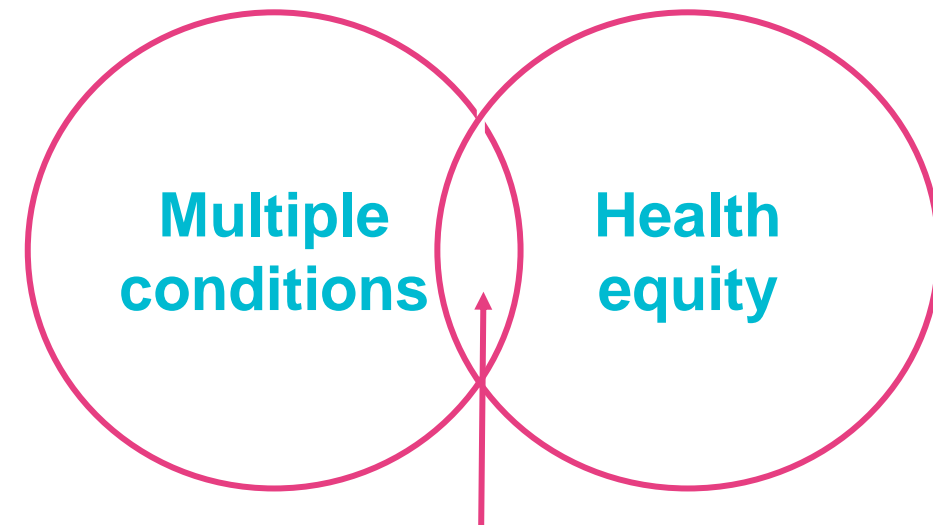
11 May 2021

11am–12pm Launch event

Time for Primary Care Networks to act

8 June 2021

11am–12.30pm Exploring Solutions

Primary Care Networks, multiple conditions and health equity

Watch the videos here

6 July 2021

11am–12.30pm Roundtable discussion

Enabling Primary Care Networks to act

Multiple conditions

Health equity

The events focussed on issues at the intersection of multiple conditions and health equity.

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Our starting point

- The burden of multiple conditions is unevenly distributed – women, people living in poverty, people with disabilities, ethnic minorities and other **marginalised and stigmatised groups are disproportionately affected.**

- Those living in the most deprived areas are developing conditions on average **10-15 years earlier** than those living in the least.

- The pandemic has exposed and amplified underlying inequalities: the presence of two or more long term health conditions is linked to a **48% higher risk of a positive COVID-19 test**. Those of an ethnicity other than white, who also had multimorbidity, had almost **three times the risk of a positive COVID-19 test.**
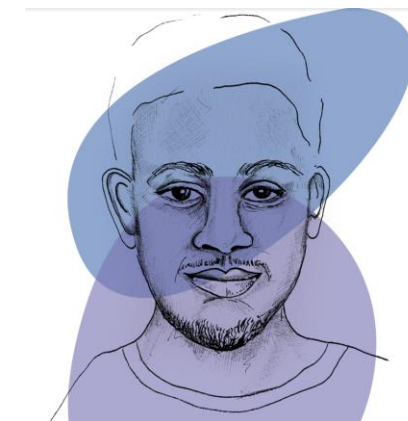
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Launch event: Who did we hear from?

Event 1 focused on race and ethnicity in connection to MLTCs. We heard from a range of expert speakers:

Neil Tester
Director
The Richmond Group

Natalie Creary
Programme Delivery Director
Black Thrive

Dr Pramit Patel
PCN Leader - Surrey
Heartlands Health and Care
Partnership

Josie Garrett
Health Policy Officer
Friends Families & Travellers

Bekele
Expert by Experience

Launch event: What did we discuss?

- We first heard **Bekele's** reflections on living with MLTCs and facing racial and geographical health inequalities. Bekele feels when GPs are over subscribed, patients receive lower standards of care. He noted this largely impacts ethnic minority groups as they are more likely to live in lower socioeconomic areas.

- **Josie Garrett**, Friends, Families and Travellers, then spoke about the barriers to healthcare faced by Gypsy and Traveller communities. Josie called attention to the **Inclusion Health Tool** which highlights simple adjustments that can be made and support PCNs to tackle inequalities in local neighbourhoods.

- **Natalie Creary** from Black Thrive highlighted that we need to be more critical of the evidence base. Research and service design interventions often do not involve black people in the studies – to what extent will these interventions take account of a communities' racialised experience and whether an intervention is culturally relevant?

- **Dr Pramit Patel** emphasized that systems need to be designed around **real patient experiences.** He noted PCNs should be working towards combating the medicalisation of poverty and making healthcare more accessible. Pramit questioned how PCNs can **work with community leaders** to address the wider determinants of health.

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Learning from event 1: what did we discuss?

"We know that good work is a protective factor. Black communities experience significant barriers to accessing and sustaining good work, and this has been exacerbated by the COVID-19 pandemic."

Natalie Creary – Black Thrive

"It is possible to make small changes that will make a big difference to those with the greatest needs, and that this can improve things for everyone."

Josie Garrett – Friends, Families and Travellers

"40% of people who come to general practice are struggling with 'life'. Are we the best people to help address their needs? Not always. PCNs are multi-disciplinary by design. PCNs are not just a collaborative of general practice and should not fall on just one organisation. Our ambition should be to improve the health and wellbeing with our local communities, for our local communities."

Dr Pramit Patel **– PCN Leader, Surrey Heartlands Health and Care Partnership**

"Doctors and healthcare workers in poorer areas might be overstretched and might not be able to give the same standard of service to everybody."

Bekele – Expert by experience
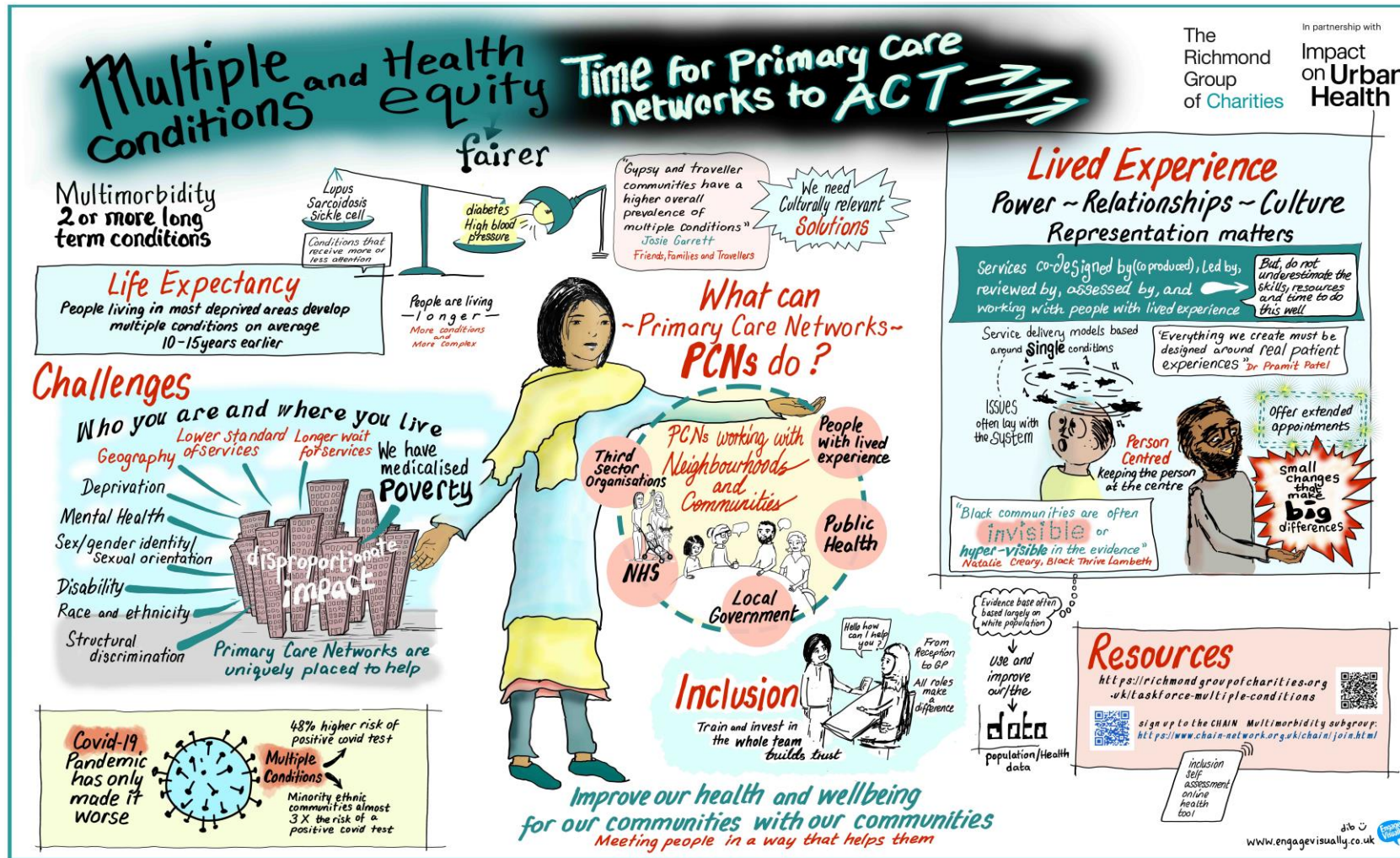
Event 2: Exploring solutions

Event 2 was more solutions focused. We heard from a range of expert speakers:

Dr. Nav Chana
National Association of
Primary Care

Olivia Butterworth
NHS England & Improvement

Yasmin Ibison
Black Thrive

Rachel Brennan
Groundswell

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Learning from event 2: what did we discuss?

"Black people acquire MLTCs approximately **10 years earlier** than their white counterparts and are more likely to be unemployed or in low paid work. PCNs can encourage systematic collection of inequalities data to support and lead change."

Yasmin Ibison, Black Thrive

"There are a variety of **barriers homeless people face** when trying to access healthcare. These include **practical barriers** of actually getting to appointments (i.e lack of funds), a **lack of trust** due to perceived and actual discrimination and the **challenges of navigating** the healthcare system without the appropriate documentation. "

Rachel Brennan, Groundswell

"People's conditions escalate significantly before they are able to access the services they need. Partly due to demand on services and partly because the referral thresholds are so high. Can we build local partnerships that support earlier intervention? **at place level**, and introduce into PCNs a wider range of roles , including health coaches, physios, community paramedics, community pharmacy and more."

Olivia Butterworth, NHSEI

"Homelessness is a **risk factor for tri-morbidity** . Homeless people attend A&E 6 times as often as the general public, are 4 times more likely to be admitted and once admitted stay **3 times longer** than the general public. The average age of death is 47 for a homeless man and 43 for a homeless woman."

Rachel Brennan, Groundswell

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Exploring solutions: key learning

Areas for PCN prioritisation:

- Apply a **race and a multiple conditions lens** to everything you do!

- **Easier access to healthcare:** GP registration, flexible access to appointments, providing a range of ways to access care including community based delivery of care

- **Collect and publish equalities data** relating to all commissioned services. Use this data to inform action.

- Develop a **diverse pool of community health partners** and work in partnership to share referrals, best practice, data, and resource. Model a culture of collaboration rather than competition.

- **Widen the network of residents** involved in PCNs or develop new mechanisms for residents to feedback and input into service design. Focus on building community leaders.

- **Listening to the community:** understanding of local barriers to accessing care and commitment to work together with people who have lived experienced (e.g. the #HealthNow peer support model)

- **Education and resources:** training for staff in homeless and inclusion health. Building local directories services for active signposting

Roundtable: Who did we hear from?

The final event was a roundtable discussion to agree what **actions** could be taken to better improve healthcare for those living with multiple conditions. The roundtable brought together stakeholders from:

- NHS England and NHS Improvement
- NHS Confederation
- Royal College of General Practitioners
- Royal Pharmaceutical Society
- Health Education England
- Healthwatch England
- Coalition for Personalised Care
- National Association of Link Workers
- Stroke Association
- Centre for Mental Health

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Roundtable: What did we discuss?

- The group discussed the complexity and confluence of disadvantages people face in access and outcome of healthcare provisions. Multiple conditions add further to this inequity.
- The group pointed to the treatment backlog as complex and growing and will likely be a high priority for the health system for the foreseeable future. Pandemic aside, long-standing and intractable challenges remain.
- We still approach multi-morbidity through a biomedical lens and there is a tendency to treat each condition separately rather than taking a holistic approach.

There is opportunity in the current and emerging landscape:

- Partnership working is a key requirement in ICS legislation.
- Covid-19 has led to heightened awareness of both long-term conditions and health equity and the recognition that community assets are a necessary part of service delivery.
- PCNs have the potential to facilitate much better coordination and use population health management to improve outcomes for people with multiple conditions. However, they will need support for this given the pressures they already face and resource constraints.

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Roundtable: What did we discuss?

The group felt that it was important to continue to raise awareness of these issues:

- Making the economic argument and highlighting that those with long-term conditions account for 75% of NHS activity currently and this number will only set to grow with the ageing population.
- Identify where can we join our voice with other coalitions that are promoting the same messages for greater impact and truly inform policy and practice change.

But there were calls for realism in the face of workload and constrained resource:

- Whilst Primary Care Networks have potential to broker some of these changes, particularly regarding population health, PCNs are at varying degrees of maturity – some remain incredibly fragile and struggle to carry out the 'day job'.
- We should look for opportunities within the existing structures, including examining how we can use the additional roles in PCNs to make them more of a multidisciplinary team e.g. the role of Community Pharmacy.
- Need to continue to target, identify and respond better to disadvantaged groups that are too often voiceless and hidden in the data. With resource constraints, better segmentation and targeting is critical if the right support offers are to reach the right people using the channel that suits their needs best.

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Taking action: National priorities

- NHS England and NHS Improvement, ICSs, PCNs and health and care providers encouraging professionals to **apply an inequity lens** to their support for people with multiple conditions.

- **Stakeholders to join up** work on multiple conditions **with existing inequalities** programmes – such as NHS England's health inequalities strategy and the RCGP's Health Inequalities group.

- **Encourage social prescribing** and **engage with programmes** such as Rethinking Medicine and personalised care programmes such as shared decision-making to move away from medical models of care.

- Build **genuine partnership** working with **voluntary, community and social enterprise (VCSE) organisations** – recognising the fundamental role they play in supporting people with long-term conditions and the pressures they relieve on NHS and social services.

- **Enable services** that are especially connected to their local communities – such as pharmacists and VCSE organisations – to have **access to patient information** so that they can provide the best support.

- Use **co-production** and related models to develop services for people with long-term conditions, ensuring that **diverse patient voices** are heard and actively involved in the process. Championing patient participation groups, co-design and co-production but acknowledging that training and a specific skillset is needed to do this well.

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Taking action – where next?

The group suggested some specific roles and responsibilities for the Richmond Group:

- Convening and connecting existing initiatives e.g. taking this discussion to the Coalition for Personalised Care group and RCGP Health Inequalities group to link efforts.

- Identifying areas of good practice and communicating them so commissioners and policymakers can be informed by what works on the ground.

- Supporting moves towards thinking about outcomes in terms of experience and outcome measures rather than counting input measures.

- Acting as a bridge between NHS and VCSE – in many areas the system needs support with how to approach the VCSE and create sustainable community based solutions.

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Resources

Resources shared in event discussions are collated below

- [Inclusion Health Tool](#)
- https://elearning.rcgp.org.uk/mod/page/view.php?id=11930
- https://www.nwlondonccg.nhs.uk/coronavirus/vaccine-equity-work-us
- https://fairhealth.org.uk/
- https://www.bmj.com/content/368/bmj.l6964
- https://www.gresham.ac.uk/lectures-and-events/health-trends
- https://www.england.nhs.uk/personalisedcare/upc/comprehensive-model/
- https://www.nalw.org.uk/research-committee/
- https://lpwp.org/

Thank you

Thank you for being part of this event series. Now is the time for all of us – as individuals and organisations – to take action. As the Taskforce ends and The Richmond Group continues to put multiple conditions and health equity at the heart of our strategy we will continue to apply this lens to our work to influence policy and practice.

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