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# Long-term Conditions (LTCs)

Public Health and Health Integration  
Scrutiny

4<sup>th</sup> March 2025

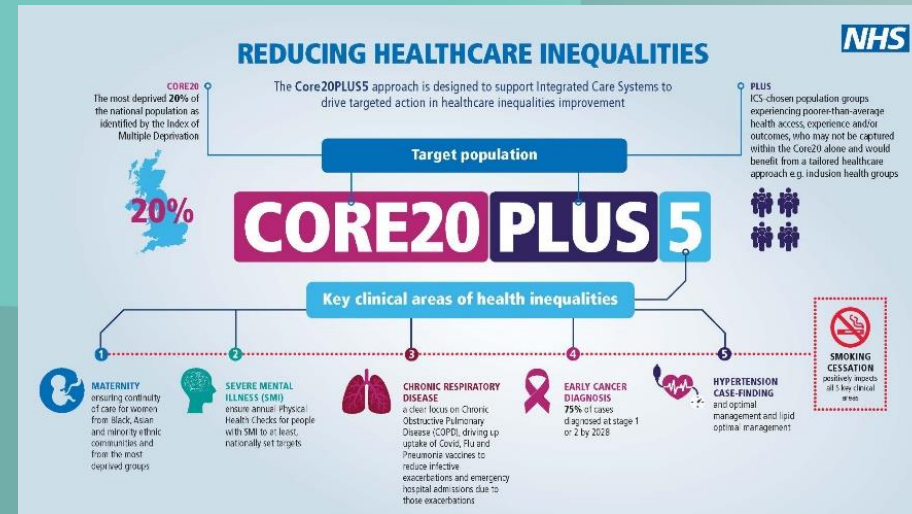
# Overview

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- This presentation will cover:
  - Strategic justification for LTCs focus for 24-25
  - Core principles and approaches
  - Hypertension
  - Multiple LTCs
  - Links and alignment to other areas of LTCs covered across the Public Health team
  - Partnership work with Primary Care Networks
  - Prevention of LTCs
  - Future direction of LTCs work

# Strategic justification for LTCs focus for 24/25

- Leicester's Health, Care and Wellbeing Strategy 2022-2027
- Prevention and Health Inequalities Steering Group
- Primary Care Networks (City)
- Core20plus5 clinical area



# Core principles and approaches

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Prevention  
first

Reducing  
health  
inequalities

Data-driven

Evidence-  
based

Address gaps,  
avoids  
duplication



Leicester  
City Council

# Hypertension (persistent high blood pressure)

## Evidence of the need

- Often called “the silent killer”
- Primary risk factor for death and illness related to cardiovascular disease (CVD)
- Most common CVD condition in Leicester
- Contributes to higher-than-average under-75’s mortality rate
- Contributes to health inequalities
- Approx 12% (n = 50,000) of city population are diagnosed
- Estimated further 24,000 have not yet been diagnosed – finding them is vital

## Existing interventions

- NHS Health Check
- Community Pharmacy case-finding
- PCN case-finding and optimisation

## Proposed approach(es)

- Community pharmacy outreach model
- Targeted NHS Health Checks
- Roving Health Unit
- PCN case-finding and optimisation

## Monitoring

Outcomes

Impact

# Multiple LTCs

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- Shift away from single condition work.
- Focus groups work (collaboratively with PCNs/Voluntary sector)
- Multiple LTCs development session (Health and Wellbeing Board)

# LTCs work across other areas of Public Health

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- LTCs are encompassed within a range of other public health activity, including:
  - CVD
  - Mental Health
  - Obesity
  - Cancer
  - Respiratory conditions

# Partnership work with PCNs

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- Focus groups with patients
- Public Health support offer to PCNs
  - Support offer to help achieve 24/25 priorities
  - Health inequality plans
- Drive towards neighbourhood health management



# What is Making Every Contact Count?

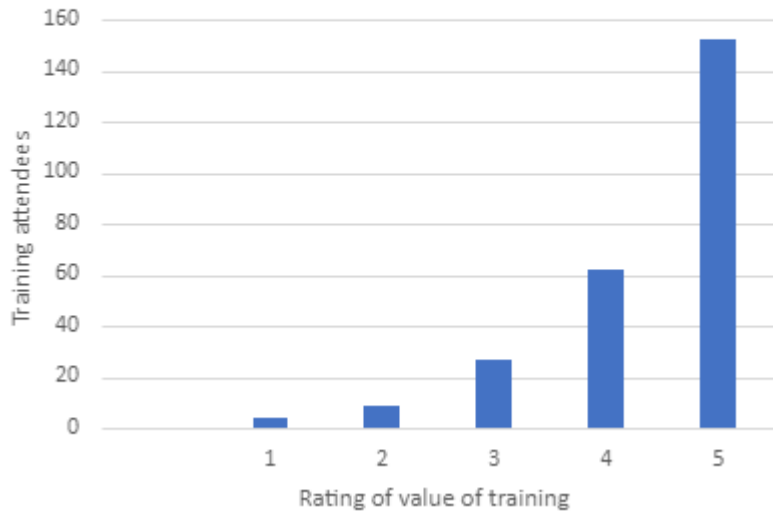
‘Enabling the **workforce** to **recognise the opportunity** they have in facilitating people to have a greater awareness of their health and wellbeing’



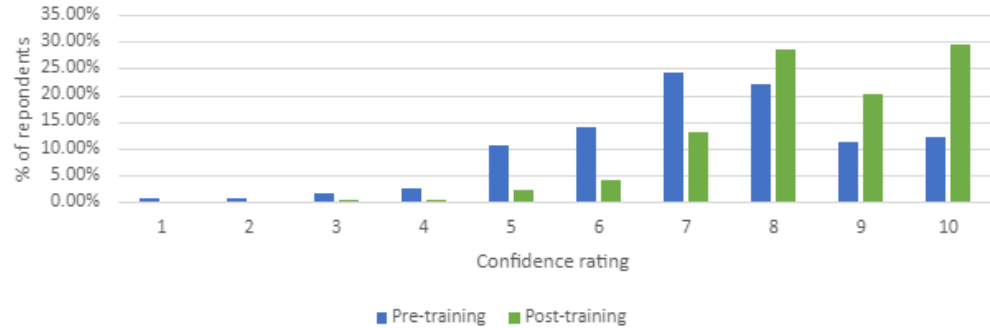
**Everyone has the opportunity to have a healthy conversation**

# Prevention of LTCs - MECC

Perceived value of training attendees as per the post training survey (scaled 1(not at all valuable) to 5 (very valuable))



Bar chart demonstrating how confident individuals feel about supporting others in making positive/healthy changes at both pre and post HCS/MECC+ training.



# Future direction of LTCs work

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Learning & best practice from hypertension work to shape other programmes

Continue MECC roll-out across relevant staff groups

Gap analysis to identify further areas of need

Cross-cutting areas – e.g. healthy ageing (frailty)