Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD

Theme of Meeting	Healthy Aging
Title:	The challenges posed by multi-morbidity and the impact of social isolation
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Date:	**28th November 2019**

EXECUTIVE SUMMARY:

Multi-morbidity is commonly defined as the presence of two or more chronic medical conditions in an individual and it can present several challenges in care particularly with higher numbers of coexisting conditions and related polypharmacy. Nationally and locally initiatives are being delivered to begin addressing these challenges.

Social Isolation is similarly a growing concern, and it does not immediately appear as an issue that is in the NHS gift to address. However it it's increasingly being seen that addressing it, there is a positive impact on a person's ability to keep well. Age UK, in partnership with the CCG and Public Health; have developed a service to tackle loneliness that has already seen significant levels of referrals from City GP Practices.

Contributing to the objectives of the Joint Health and Wellbeing Strategy:

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note the paper

Background Information:

Introduction

Multi-morbidity refers to people having more than one illness at the same time. We know that seventeen million people in the UK have a chronic illness and that many of these people have at least two illnesses.

The size of the challenge:

Recent analysis by the Health Foundation highlights the scale of the challenge, revealing that one-in-four adults in England are now living with two or more health conditions, which are around 14.2 million people in total[1]. Half of all primary and secondary care consultations and admissions are for multi-morbid patients.

The number of people living with multiple health conditions is expected to rise significantly over the time frame of the long term plan, with both projected hospital activity and costs up by 14% and £4bn over the next five years respectively.

However, multi-morbidity is not just a problem of ageing.

Nearly a third (30%) of people with 4+ conditions are under 65, and this is higher in deprived areas. For patients, the impact of living with multi-morbidity can be profound. People with multiple health conditions have poorer quality of life, difficulties with everyday activities and a greater risk of premature death.

The nature of the challenge[2]:

1. Increasing multi-morbidity is associated with higher costs and use of the healthcare system
2. Multi-morbidity is often associated with disability and the progressive need for support with activities of daily living.
3. Multi-morbidity is the norm.
4. Multi-morbidity, more than age, drives emergency admission costs.
5. Multi-morbidity is distributed throughout the population and does not just occur in the elderly.

[1] https://www.health.org.uk/publications/understanding-the-health-care-needs-of-people-with-multiple-health-conditions

[2] These points will be expanded using the attached slides

6. Not All Patients with a Particular Long Term Condition (LTC) are the Same

Addressing multi-morbidity:

There are a number of changes being made locally to begin addressing some of the issues presented by multi-morbidity, examples include:

- *Being more person centred* :

The NHS Long term plan recommended making personalised care available to more patients, widening access to social prescribing, and improving coordination of care and links with social care. Leicester City CCG, along with partners in the social care sector is working to develop a more integrated system of care.

- *Planning and data sharing*

A well thought out collaborative planning process is crucial for people with multi-morbidity. This identifies what's most important to people. It is equally important to share (where appropriate) and keep readily available and regularly updated documentation of the outcomes of discussions and decisions made. The enhanced summary care (eSCR) record can help coordinate across care settings (including Secondary care and Ambulance crews) by enabling the sharing of key information, subject to patients' explicit consent.[3]

- *Addressing Fraility* :

Frailty can predate crisis by a decade or more[4] and many people with frailty also have multi-morbidity. The electronic Frailty Index (or eFI),uses existing coded data from the electronic primary care record to identify frailty in people aged 65 years or over.

- *Planning for Integrated care (PIC) in General Practice*

The PIC GP scheme in Leicester aims of this scheme is to improve the quality of care, the quality of patient and carer experience as well as improve the clinical outcomes for patients with frailty and/or multi-morbidity and/or predicted high cost and/or those with none of the above but whom are in need to extra input to help them manage their long term condition.

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[3] https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients

[4] https://www.england.nhs.uk/blog/martin-vernon-2/

Tackling Loneliness.

In the last few years loneliness has been identified as a significant public health challenge.

Three quarters of GPs surveyed say they see 1 to 5 people a day who are suffering from loneliness has been linked to conditions such as heart disease, strokes and Alzheimer's. 200,000 older people haven't had a conversation with a friend or relative in the past month.

The number of over 50s suffering from loneliness is set to reach 2 million by 2025/6. This amounts to a 49% increase in 10 years[5]

In Leicester's Health and Well-being survey (2018) it was reported that around one in ten residents feel lonely or isolated often or all of the time. In addition, it was found that 7% of over 65s feel this way and 30% of our sick and disabled residents feel lonely.

In October 2018 the government launched its policy paper, "A Connected Society: A Strategy for Tackling Loneliness"[6]. In this paper, it was recommended that the NHS tackle loneliness by developing Social prescribing schemes. Social prescribing is also a part of the NHS Long term plan and the Primary Care Network model.

NHS England estimates that 60% of Clinical Commissioning Groups have already commissioned some form of social prescribing scheme and is currently compiling evidence and developing a common outcome framework for use by CCGs.

Leicester City CCG is in discussion with Public Health, local VSCE and PCNs about how to develop a city wide Social Prescribing model that builds on existing services.

An example of an existing service is the Loneliness prescription service delivered by Age UK [7]

The Loneliness prescription service

Leicester Aging Together[8] (LAT) is part of Ageing Better, a programme set up by The National Lottery Community Fund. The programme is focused in 5 city wards: Belgrave, Evington, Thurncourt, Spinney Hills and Wycliffe. These were selected because of the prevalence of risk factors associated with social isolation which have been identified by older people

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[5] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report.pdf

[6] https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness

[7] https://www.ageuk.org.uk/bp-assets/globalassets/leicester-shire--rutland/original-blocks/our-services/our-leaflets-and-guides/aulsr-guides/2019/loneliness-prescription-service---jan-19.pdf

[8] https://www.leicesterageingtogether.org.uk/

One of the partner agencies in LAT, Age UK, developed a Loneliness Prescription service. This proved to be successful with GPs in the selected areas, consequently Age UK have expanded their offer to cover the entire city.

City CCG and Public Health have worked with Age UK to refine the service, to ensure that it engages well with current services and that referrals reflect need as closely a possible . To date, the service has delivered some interesting results.

Activity for quarter one of this service is detailed below:

Referrals From	Number	Percentage
Care Navigators	71	80.68%
GP or Pharmacy	14	15.91%
Other Health Source	3	3.41%
	88	100.00%

Fig1: age UK Loneliness prescription service - referral activity Q1 2019/20

Self-reported condition	Number
Physical disability	48
Mental health condition	4
Dementia	3
Learning disability	0
None / not yet asked	33

Fig2: age UK Loneliness prescription service - referred patients self-reported conditions Q1 2019/20

Referrals To:	Number
Caring for Carers	15
Telephone Befriending	14
Mentoring	9
I & A	8
Leicester Charity Link	7
LCC (Adult Social Care) / (OT)	7
Lunch Clubs	4
Social Groups	3
Vista	2
MacMillan	1
Digital Champions	1
Call-in-Time	1
Dial-a-ride	1
Total	73

Fig1: age UK Loneliness prescription service - onward referrals from Age UK Loneliness prescription service Q1 2019/20

Indicative of the level of need is that fact the age UK have already exceeded their GP referral target of 160 for 2019/20. However, there are a number of reasons to find this an encouraging development;

1. GP practices are acknowledging that there is a problem, and
2. that they are comfortable in referring to this service as a part of addressing that.
3. Because the referrals are predominantly via the Care Navigators, this increased the chances of the individual getting an holistic assessment and being linked up with other statuary and non-statutory services, this maximises support and can further reduce isolation

Coverage is not universal yet and not all CCG practices are referring, but the CCG is working with practices to encourage them to refer into the service and the CCG and Public Health will continue to support the service and monitor activity.

The implications of the activity and type of onward referrals made by Age UK will be used to inform future strategy.