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Multimorbidity Advice Note

July 2014

Purpose

This note contains information about the National Action Plan for Multimorbidity as referenced in recent Guidance for local partnerships on the Integrated Care Fund.

Multimorbidity

The Public Bodies (Joint Working) (Scotland) Act addresses an ambitious agenda that is firmly focused on prevention, on the alleviation of health inequalities, and on improving care and support for adults who have multiple or complex health conditions (often referred to as multimorbidity).

Over two million people in Scotland have long term conditions and this number is projected to rise as the population ages and as a consequence of increasing levels of risk factors for chronic disease at all ages. In fact, most people with multimorbidity in Scotland are under 65 years.

Current evidence suggests that deprivation influences both the amount and the type of multiple conditions that people experience. Multimorbidity occurs 10 -15 years earlier in deprived areas compared to affluent areas.

A greater mix of mental and physical health problems is seen as deprivation increases, which increases clinical complexity and the need for holistic person centred care. A combination of physical and mental health conditions has a strong association with health inequalities and negative outcomes for individuals and families.

Emergency admissions to hospital, attendance at A&E and prescribing costs are rising, particularly in areas with a high prevalence of multimorbidity. Annual adult health and social care spend is projected to rise with increasing demand associated with demography, multiple complex conditions and multiple prescribed medicines.

To improve health and wellbeing outcomes, especially in less affluent communities, we need a more integrated approach to housing, healthcare and support designed around the needs of people with multiple conditions.

Multimorbidity Action Plan

The Multimorbidity Action Plan is the next phase in Scotland's commitment to improve the health and wellbeing of people with long term conditions. It builds on progress in implementing the 2009 **Long Term Conditions Action Plan** and draws on the learning from the Long Term Conditions Collaborative.

The 2014 Action Plan for Multimorbidity aims to ensure that:

All adults with multiple conditions are supported to live well and experience seamless care from the right person when they need it and where they want it. Scotland further enhances its reputation as a world leader in research and innovation in Integrated Care and multimorbidity.

These ambitions will be realised through changes delivered at different levels:

- through individual care encounters;
- within localities through different relationships between local communities and locality integrated teams and services;
- through system wide person centred pathways;
- by national actions to further support innovation and improvement

These are described as the 4 Primary Drivers of change:

- Care planning and consultations that help people to have control over their conditions, care and support and to achieve their personal outcomes

- Integrated care and support that builds on community assets and promotes independence, wellbeing and resilience

- Whole system pathways that are designed around people with multiple conditions and aim to reduce health inequalities

- Visible adaptive leadership and a coherent research, innovation and improvement infrastructure that drives excellence in Integrated Care for Multimorbidity

Annex 1 lists ten actions for the new integration authorities and their partners, and five national actions that will collectively deliver these changes.

The ALLIANCE Academy, drawing on the rich life experience from their network of people affected by multiple conditions, is working with the JIT and the Scottish Government to gather personal stories and other resources to provide a supporting narrative for the Action Plan.

As a first step, JIT and the ALLIANCE jointly hosted the *My Health My Care My Outcomes* learning event on 28 May 2014. This followed a conference on multimorbidity in collaboration with the Royal College of Physicians and Surgeons of Glasgow.

Presentations from the event on 28th May can be accessed at
http://www.jitscotland.org.uk/news/multi-morbidity-event-glasgow/

Outcomes

We know what matters most to people with multiple conditions is:

- Coordination and continuity of care
- Trusted relationships
- Accessible information and advice
- Good communication with, and between, staff.

The "My Health and Care Pathway" **(Annex 2)** illustrates what matters to people affected by long term conditions.

This work has been informed by the My Condition, My Terms, My Life campaign led by the ALLIANCE and draws on the report of a conference held in 2011 involving people who live with multiple conditions.[1]

However current health and care systems are not geared to deliver these outcomes. Fragmented care from multiple professionals and teams disrupts lives, increases the burden of treatment for individuals, their families and carers and increases costs, waste and risk of harm. Transitions of care are a particular pressure point. We don't routinely support people to use their individual and community assets to build resilience, prevent or delay dependency and reduce demand for more intensive support.

Innovation and Improvement

The Integrated Care Fund should be used to test and drive innovative and preventative approaches to improve health and wellbeing outcomes by supporting the assets of individuals and communities so that they have greater control over their own lives and more capacity for self management and self directed care and support.

This will involve deepening our focus on personal outcomes; supporting health literacy; adopting a co-production approach; using technology to enable greater choice and control; and adopting an assets-based societal model to improve population health and wellbeing.

The third sector has a crucial role to play in supporting this approach and in promoting self management and self directed support.

For information on the Self Management Fund visit the ALLIANCE website www.alliance-scotland.org.uk. For information on Self Directed Support search the SDS library.

[1] See http://www.alliance-scotland.org.uk/download/library/lib_4e858df323e51

JIT workstreams on personal outcomes, coproduction, community capacity building and telehealthcare will also support your work on multimorbidity.

Contact

For further information on the Multimorbidity Action Plan contact Dr Anne Hendry, National Clinical Lead for Integrated Care: Anne.Hendry@scotland.gsi.gov.uk.

Useful Resources

Anticipatory Care Planning
http://www.qihub.scot.nhs.uk/quality-and-efficiency/outpatient-primary-and-community-care/primary-and-community-care-.aspx

Care Planning in General Practice for people with LTC
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx

Emotional Support Matters and **Living Better Report** http://www.alliance-scotland.org.uk/resources/library/grid/1/type/2/topic/all/tag/7/condition/all/download/library/lib_4e3ab46435632/

House of Care in www.yearofcare.co.uk and in Kings Fund
[1]http://www.kingsfund.org.uk/blog/2013/10/supporting-people-long-term-conditions-what-house-care

Integrated Community Ward / Virtual Ward case studies and stories are at Intermediate Care Community of Practice

Key Information Summary www.keyinformationsummary.org.uk

LINKS worker Www.improvinglinks.scot.nhs.uk and http://www.alliance-scotland.org.uk/what-we-do/projects/linksworkerprogramme/

'**Living Well with Long Term Conditions**' report

Long Term Conditions Action Plan – 2009

Multiple long term conditions report http://www.alliance-scotland.org.uk/download/library/lib_4e858df323e51

Polypharmacy reviews - guidance within CEL36

Self-Management: The Health Foundation, Self Management Works 2013
http://personcentredcare.health.org.uk/resources/self-management-works

'Gaun Yersel' **The Self Management Strategy for Scotland**

Self Directed Support Search the library

Self Management campaign: My Condition, My Terms, My Life

SPARRA risk prediction tool http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/

Technology enabled care and support – case studies and resources
www.sctt.scot.nhs.uk; www.livingitup.org; www.aliss.org

www.jitscotland.org.uk/action-areas/telecare-in-scotland/
www.knowledge.scot.nhs.uk/telehealthcare.aspx

Recent Reviews

Kings Fund

2012 - Long-term conditions and mental health: The cost of co-morbidities
2013 - Co-ordinated care for people with complex chronic conditions
2014 - Supporting People to Manage their health

Health Foundation

2013 – Enabling People to Live Well: fresh thinking about collaborative approaches to care

Publications on Multimorbidity

Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet 2012; 380:37-43.

Mercer S, Guthrie B, Furler J, Watt G, Hart JT. Multimorbidity and the inverse care law in primary care. BMJ 2012; 344:e4152

Mercer SW, Gunn J, Bower P, Wyke S, Guthrie B. Managing patients with mental and physical multimorbidity. BMJ 2012; 345.

Guthrie B, Payne K, Alderson P, McMurdo MET, Mercer SW. Adapting clinical guidelines to take account of multimorbidity. BMJ 2012; 345:e6341.

Hughes L, McMurdo MET, Guthrie B. "Guidelines for people not for diseases: the challenges of applying UK clinical guidelines to people with multimorbidity." Age and Ageing 2013; 42:62-69.

Payne R, Abel G, Guthrie B, Mercer SW. The impact of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study. CMAJ 185 (e-publication ahead of print): E221-E228, 2013, doi:10.1503/cmaj.121349

Mercer SW, Watt GCM. "The Inverse Care Law: Clinical Primary Care Encounters in Deprived and Affluent Areas of Scotland." Ann Fam Med 2007; 5:503-510.

O'Brien R, Wyke S, Guthrie B, Watt G, Mercer S. An ‘endless struggle’: a qualitative study of general practitioners’ and practice nurses’ experiences of managing multimorbidity in socio-economically deprived areas of Scotland. Chronic Illness 2011; 7(1):45-59.

Gallacher K, May C, Montori VM, Mair FS: Understanding Treatment Burden in Chronic Heart Failure Patients. A Qualitative Study. *Annals of Family Medicine* 2011, 9: 235-243

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Annex 1 Ten Local Actions – for NHS Boards and Partnerships

Primary Driver	High Impact Changes	Actions for Boards and Partnerships
Care planning and consultations help people to have control over their conditions, care and support and to achieve their personal outcomes	***Outcome based assessments*** • Staff ask people about the priorities, goals and outcomes that matter to them • Consultations routinely include time for reflection, to 'think ahead' and to 'check out' ***Holistic care planning*** • Assessments, care planning and reviews support people to develop a personal care plan • People prescribed multiple drugs receive support to understand and manage their medicines	• Adopt *House of Care* consultation model in GP practices and spread personal outcomes approaches in community teams • Design holistic GP practice and outpatient appointments for people with multiple conditions • Scale up Anticipatory Care Planning in primary care and use of Key Information Summaries in unscheduled care • Roll out Pharmaceutical Care Planning and reviews
Integrated care and support builds on community assets and promotes independence, wellbeing and resilience	***Self Management information, advice and support to help people stay well, active and at work*** • Peer support and volunteers are an integral part of local practices, integrated teams and services • Patients and carers use day to day technology and social media to manage their conditions ***Build enablement and generalist skills in the workforce*** • All education and CPD programmes deliver units of learning on multimorbidity, enablement, health behaviour change and working health	• Introduce practice attached support workers / community navigators and simplify access to local community support • Scale up use of digital information, guided self help, remote monitoring and consultation • Extend health coaching and health promoting interventions to all care settings • Develop roles, job shadowing and action learning to enhance generalist skills in specialist care and specialist expertise in community workforce
System wide pathways designed around people with multimorbidity and to reduce health inequalities	***Coordinated, Integrated technology enabled care*** • MCNs, care pathways, protocols and guidelines are attuned to people with common multimorbid syndromes and concurrent physical and mental health problems • Proactive care coordinated by a lead professional or care manager	• Support MCNs to develop single point of access, screening prompts and technology enabled decision support for people with multiple morbidity at key points in local pathways • Systematically identify people with multimorbidity and deliver stepped care using peer, Third sector, technology and professional support tailored to needs and complexity

5 National Actions – for Scottish Government, NHS Special Boards and Academic partners

Primary Driver	High Impact Change	Actions for Scottish Government, Special Boards and Academic partners
Visible adaptive leadership and a coherent research, innovation and improvement infrastructure to drive excellence in Integrated Care for Multimorbidity	***Leadership, research and innovation*** Integration authorities and their Third and independent sector partners have the capacity and capability for improvement and innovation in integrated care and multimorbidity Scotland's digital and social innovation align to develop an ambitious programme of collaborative research, innovation, and knowledge exchange with global experts on integrated care and multimorbidity	• Map and build local capacity for integrated improvement to support the 10 local priority actions • Enhance risk prediction tools, disease register templates and data on common combinations of long term conditions • Include prompts to consider multimorbidity at key points in guidelines and pathways for all common conditions • Develop units of learning on Multimorbidity for multiprofessional undergraduate and CPD programmes • Establish a Knowledge Innovation Community and 'collaboratory' on Integrated Care and Multimorbidity

Annex 2: My Health and Care Pathway

Preventative and Anticipatory Care	Proactive Care and Support at Home	Care at Times of Transition	Unscheduled Care
I am given information, and advice on opportunities to stay well and be physically active	I agree my own care plan for responsive, flexible and personalised support	I have a single agreed point of contact for my community health and care team	If I phone NHS 24 or attend A&E the staff take note of my wishes from my Key Information Summary
I am offered emotional and psychological support from my peers, local community or professionals	My care plan identifies any help I may need to remain in work	I receive the help I need to understand and to manage my medicines	The specialists I see talk with each other and agree who will coordinate my care while I am in hospital
I develop my own 'Thinking Ahead' Anticipatory Care Plan	I can access the equipment or support I need by one call	If I do not wish to attend more than one hospital clinic I can be seen in a 'one stop shop'	My case manager and the team who usually oversee my conditions know that I am in hospital and why
My GP shares my Key Information Summary and ECS with the emergency teams	I am able to stay safe and can monitor my conditions at home using everyday technology	I know how to be seen urgently by my GP or specialist team if any of my conditions suddenly flares	I return home with the support I need without delay, or am transferred for care closer to home
My practice offers me longer consultation times with my nurse or GP	I have a named Case Manager to coordinate my care and support if it is complex	If I start to become more dependent I am offered review and rehabilitation	Staff review my medicines with me and check my understanding of any changes
My home and housing support help me stay well	Staff know if I have a carer and my carer feels supported	When any of my conditions requires it I receive excellent palliative care	My GP, local pharmacist and I receive a summary within 48 hours of my discharge

Communication, choice, control, continuity, coordination, community, collaboration