

The Multiple Conditions Guidebook

*CASE STUDIES AND PRACTICAL
SOLUTIONS TO HELP LOCAL AREAS
IMPROVE HEALTH AND WELLBEING*



Taskforce on Multiple Conditions
November 2019

The
Richmond
Group
of Charities



**RC
GP** Royal College of
General Practitioners



Contents of this guidebook

The Taskforce on Multiple Conditions is a partnership between the Richmond Group of Charities, Guy's and St Thomas' Charity and the Royal College of General Practitioners.

Launched in 2018 the Taskforce seeks to drive transformational change with and for people with multiple conditions.

The shared vision is for people with multiple conditions to live as well as possible for as long as possible because the following has been achieved:

- The development of multiple long-term conditions is delayed or prevented.
- Where people live with multiple long-term conditions, health and care services and the voluntary sector's offer are well aligned to manage and support them.

<https://richmondgroupofcharities.org.uk/taskforce-multiple-conditions>

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Foreword

The challenge of multiple long-term conditions is significant and complex. But the good news is that there is already a lot being done and there are multiple solutions. In commissioning a review of practical approaches that work with and for people with multiple conditions we hoped to find out more details about who was doing what, why and where. Our aim is to now share this learning and add to the practical tools available to improve the lives of people living with multiple conditions.

We have been heartened that the findings of the review, presented in this guidebook, confirm that there is good practice that works for people with multiple conditions. And despite the need for flexibility to take account of different personal and local circumstances, the review has found common ingredients across many approaches. It has also found that different techniques – like small shifts in practice and involving a wide range of others – can help develop and spread practical solutions. We hope you find it helpful and that you will work with us all going forward so the widest collective experience can bring about change.

We know that ten case studies is just a small part of a big jigsaw. Nonetheless we have been surprised at just how much we have learnt from studying this small number of approaches.

As a Taskforce and within our respective organisations we plan to use this report to inform our work and to connect with others trying to improve the lives of people living with multiple conditions.

We hope that this is just the start of a process. We look forward to learning from the many other interesting examples out there about how to put into practice solutions that work for people with multiple long-term conditions.

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About this guidebook

This second publication from the Taskforce on Multiple Conditions builds on earlier learning from people living with multiple conditions and highlights a selection of different practical approaches that support them. The intention is to provide insight, tools and signposting to others with first-hand experience of designing and delivering approaches that benefit people with multiple conditions.

The Taskforce on Multiple Conditions knows that there are many dedicated and innovative healthcare professionals, commissioners and academics already working alongside charities, social enterprises, public bodies and others in our communities to improve the lives of people living with multiple health conditions. But during its first year it found it surprisingly difficult to find out exactly what people were doing, where, how and why. Believing that others might face similar difficulties, the Taskforce commissioned a targeted review of practical approaches that work for people with multiple conditions.

In this guidebook ten case studies detail how things are done in practice, the lessons learned along the way and challenges that have been overcome.

Who this guidebook is for

The primary audience for this publication is local practitioners, professionals and commissioners – in our NHS, public services, care sector, charities, social enterprises and other community services - who are working with people with multiple conditions to put

solutions in place so they can live as well as possible for as long as possible. The wider background, learning and reflections that have emerged during the review may be of interest to policy professionals, national bodies and others.

The context of this guidebook

This guidebook builds on previous research by the Taskforce and its partners.

This includes:

- The first Taskforce report '[Just one thing after another: Living with multiple conditions](#)'
- The January 2018 Richmond Group of Charities report '[Multimorbidity: Understanding the challenge](#)'
- Guy's and St Thomas' Charity report '[From one to many: Exploring people's progression to multiple long-term conditions in an urban environment](#)'
- Royal College of General Practitioners '[Effective Multimorbidity Management programme](#)'

The November 2018 Health Foundation briefing, '[Understanding the healthcare needs of people with multiple health conditions](#)', is also a source of facts and figures.

Recognising that there is a vast body of relevant work to draw on in this area, the work of others is signposted throughout the report, in the section on 'learning from other research' and through references in the bibliography.

DEFINITIONS AND LANGUAGE: WHAT DO WE MEAN BY **MULTIPLE CONDITIONS**?

There are debates about definitions and language in this field but for the Taskforce the term 'multiple conditions' relates to people living with two or more chronic health conditions. These are long-term physical and/or mental health conditions that may change over time and require ongoing management.

Another commonly used term is 'multimorbidity'. Through its work the Taskforce has come to understand that this is not a term that people living with multiple conditions like or associate with. This is backed up by research from Guy's and St Thomas' Charity with Ipsos Mori on '[Framing Multiple Long-Term Conditions](#)' and further explored in volume 69 of the British Journal of General Practice in the article titled '[Multimorbidity: an acceptable term for patients or time for a rebrand?](#)' Consequently the Taskforce now uses the term 'multiple conditions'.

Summary of findings

We are still building knowledge about the causes, impacts and best ways to tackle the challenge of multiple conditions. There are multiple layers of complexity from how our individual social, environmental and economic circumstances influence our health, to the links between different physical and mental health conditions, and the way that healthcare and other public services are structured.

What we do know is that the challenge is significant. In England around one in four of us has two or more long-term conditions and this number is growing. We also know that there is a strong link with deprivation. People in more deprived areas develop multiple conditions 10-15 years earlier than in more affluent ones. As a Taskforce we think this has to change.

Multiple conditions affect the lives of the millions of people that live with them, as well as the families, friends and professionals who care for them. People with multiple conditions have poorer health outcomes and are more likely to report poorer experiences of care

and care coordination problems. While these problems are not unique to patients living with multiple conditions, the complexity and numbers of treatments to be managed are often greater than for those only living with one condition.

Health and care services can struggle to meet the needs of people living with multiple conditions if they are organised around a single disease or need. This can fragment care and result in a high 'treatment burden' as people self-manage, take treatments, interventions and have appointments for many different conditions individually.

Our previous research, '[Just one thing after another](#)', showed that loss of mobility, social connections and mental wellbeing are common for people living with multiple conditions. The impact is also felt in communities as community resilience relies on healthy residents with social connections between them. And all the impacts combined are felt by the NHS and wider society.

KEY POINTS

- In England around **one in four of us** have two or more long-term health conditions and this number is growing.
- In more deprived areas **people develop multiple conditions 10-15 years earlier** than in more affluent ones.
- People with multiple conditions have poorer health outcomes** and are more likely to report poorer experiences of care and care coordination problems.

Source: [Health Foundation \(2018a\)](#), [Richmond Group of Charities \(2018\)](#)

Other work to learn from on the principles of good care for any health condition

National Voices Peer Support Hub
www.nationalvoices.org.uk/peer-support-hub

Health Foundation research and practical guides on person-centred care
www.health.org.uk/topics/person-centred-care

Self Management UK and the Expert Patient Programme
www.selfmanagementuk.org/

Nesta's business case for people powered health
www.nesta.org.uk/report/the-business-case-for-people-powered-health/

Realising the Value
www.nesta.org.uk/project/realising-value/

The Richmond Group of Charities Doing the Right Thing programme on social prescribing
www.richmondgroupofcharities.org.uk/sites/default/files/field/image/final_for_website_-_dtrt_-_summary_of_learning_about_social_prescribing.pdf

Social Prescribing Network
www.socialprescribingnetwork.com/

Year of Care personalised care and support planning
www.yearofcare.co.uk/

Royal College of General Practitioners Person-Centred Care project
www.rcgp.org.uk/clinical-and-research/our-programmes/person-centred-care.aspx

The Queen's Nursing Institute programme on personalised care
www.qni.org.uk/nursing-in-the-community/personalised-care/

Think Local Act Personal framework for personalised care and support
www.thinklocalactpersonal.org.uk/

The good news is that there is already a lot being done. We have a lot to learn from listening to people living with multiple conditions. Many employ inventive coping strategies and show remarkable resilience and innovation by adapting their homes and lives to adjust to the challenges they face.

We can also learn from the many different approaches already in our communities that are working with and for people with multiple conditions. The ten case studies included in this review are all unique to the place, setting and people involved. Yet there are themes, or ingredients, shared across many. We identify eight that we think offer a good place to start when thinking about practical solutions for people with multiple conditions.

Many of the eight ingredients we identify are familiar and mirror the work already done by others to promote the principles of good care for any health condition. This includes elements like peer support, care coordination, person-centred care, care and support planning, social prescribing and more, much of which is now recognised by national policymakers in the [NHS Long Term Plan](#). With its vision for more personalised joined up care, if implemented, this will undoubtedly go a long way to help not just people with multiple conditions, but any health condition.

Summary continued

Policy ambition is one thing, practical change on the ground is another. In this review we find that good practice for people with multiple conditions exists, the challenge is how to spread it.

We know that change takes time. Structural issues in local systems – like siloed working, a lack of collaboration amongst different organisations and sectors, and incentive structures that reward specialism – make it hard to implement new approaches that require flexibility to reflect the unique and often complex circumstances of people and place. And it is these unique circumstances and complexities that mean it is often not possible and rarely helpful to simply 'lift and shift' one approach elsewhere.

However, we find there is much we can learn from existing practice. Looking across the case studies we identify common elements, or techniques, that can help to develop practical solutions that work for people with multiple conditions.

Again these techniques for developing and spreading practical solutions will be familiar to many of those trying to bring about practical changes. However we hope that by sharing them along with the ingredients that work for people with multiple conditions we can help people draw upon the experience of others to spread practical solutions.

As can be seen in the more detailed study of ten different approaches, the result may look and feel very different depending on the techniques used. Nonetheless we think they offer equal opportunity for people with multiple conditions to live as well as possible for as long as possible.

"IN THIS REVIEW WE FIND THAT GOOD PRACTICE FOR PEOPLE WITH MULTIPLE CONDITIONS EXISTS, THE CHALLENGE IS HOW TO SPREAD IT."



Ingredients that work for people with multiple conditions

People like me – involving peers and co-production

Recognising there is much to be learnt from people with multiple conditions themselves, many of the case studies involve people with lived experience. This can be done through involving people with multiple conditions from the outset – as part of a process often referred to as 'co-production' – reflecting that better understanding of the experiences and aspirations of people with multiple conditions results in better design and delivery of services. Another way is to actively involve people with lived experience to provide the support to others, recognising that often our first port of call is to 'other people like me'. This can be done by linking people into peer support groups or helping their creation if they don't exist. Recognising that this often needs external expert advice and support, and funding, is important for success and sustainability.

Taking the long view – focusing on prevention and sustainability

The case studies show that supporting people with multiple conditions to live as well as possible is often not a quick fix, or something that is 'done' by simply focusing on the here and now. Practical solutions often look to prevent existing conditions worsening or additional conditions developing – alongside meeting current needs and future aspirations. Projects and programmes are designed for the long term, most set up for a minimum of five years with a focus on developing sustainability. This recognises that for people to be independent they may need to depend on support over the long term.

Looking at my whole life – taking the right personal and practical steps

All the case studies demonstrate the importance of looking at the whole person – considering their families, friends and support networks, work and interests – the wider impact of multiple conditions, how others can be involved and what changes people can make to adapt to new circumstances. Care and support planning and conversations that focus on 'What matters to you' are common ways this is done in practice. These approaches, along with social prescribing more generally, encourage and enable people to take up opportunities to socialise, connect with offers of practical and emotional support and get involved in things that interest them.

Rooted in place – learning from local data and people in communities

The importance of locally tailored programmes, in both design and delivery, comes across in many of the case studies. This is seen in several different ways. Understanding the local population and their context helps to ensure that the right people are identified for support. This is then tailored for the local situation, taking account of its system and its culture, relationships and workforce. Making good use of locally collected data – from GP surgeries, councils, clinical commissioning groups, hospitals and others – to understand the population and identify who could benefit from a different type of support is a powerful tool for some of the case studies reviewed. Another way is to work with volunteers and local organisations that are embedded in communities with the necessary connections and know-how to identify and help support people with their multiple conditions.

All for one – working in partnership and fostering collaboration

Partnership working, collaboration and a spirit of 'getting the right people together in a room' is a theme in all the case studies considered. This could include involving friends, families or carers, professionals in health and social care, other public services, charities, community activities, businesses and others. Multidisciplinary teams are a way this is commonly done in health and care. Whatever the approach, finding easy ways for people to work together helps. In practice this is seen through keeping paperwork to a minimum, linking up with existing IT systems (like in GP surgeries) and having a single point of referral for professionals.

One for all – coordinating to navigate complexity

Having a dedicated point person to build a close relationship with and get help in navigating support from other partners is shown in many approaches to help overcome some of the complexity in the system. GPs are often a key coordinator of healthcare but there are also many others that play this coordinating or linking role. They could be another healthcare professional, a charity sector worker, a volunteer, peer or exercise trainer.

Time to talk – sharing conversations and aspirations

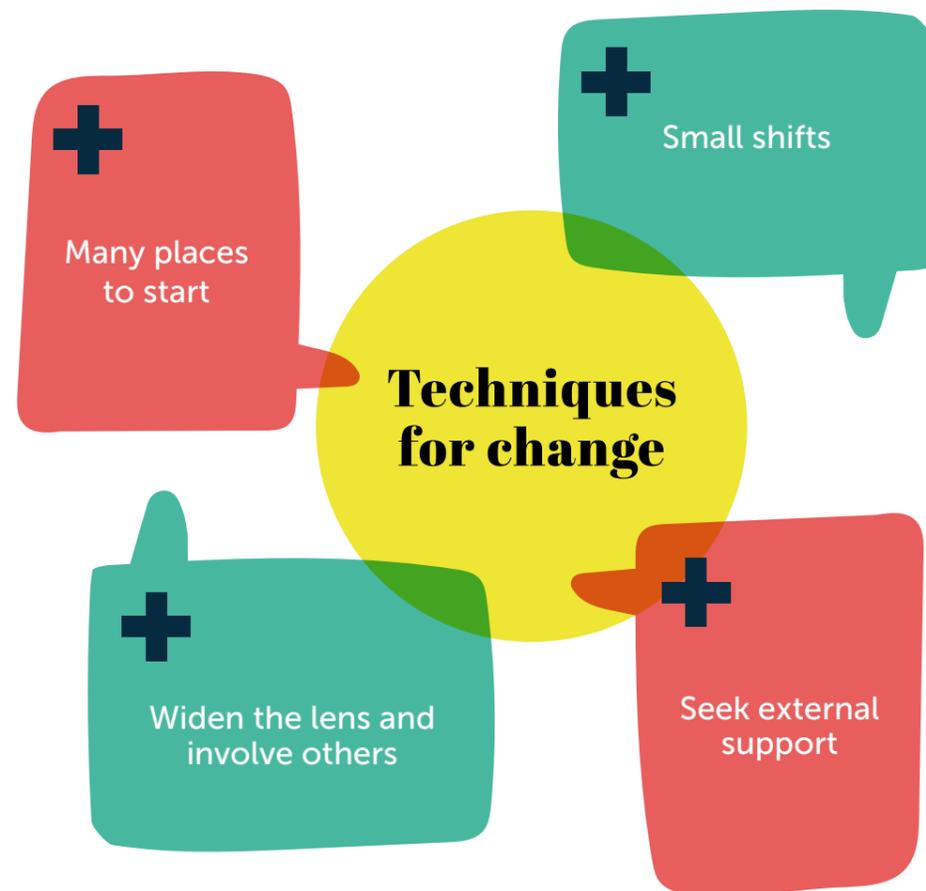
Another common theme was dedicated time for a proper conversation, whether with a care coordinator or link worker, a health coach or GP, or as part of a specific Talking Therapy. Positive, helpful conversations focus on what people would like to achieve, their future aspirations and the steps to achieving them, alongside addressing problems and needs. In many cases there is emphasis on supporting people to develop the confidence needed for self-management. In nearly all cases the time allowed is significantly more than the 10 minute slots for GP consultations currently on offer. People often work together with a professional to identify a personal plan of action to achieve their goals.

Minds matter – improving mood and wellbeing

A focus on how to deal with the impact of multiple conditions on mental health and wellbeing is central to all the approaches studied. This makes sense given an analysis of evidence by the [King's Fund](#) finds that people with multiple conditions are twice as likely to develop a mental health problem as those living without. No matter what combination of physical and/or mental health conditions a person is living with it is important that attention is paid to both the physical and mental aspects of our health. The case studies show that in practice support for mental wellbeing takes many different forms like formal counselling, connecting into therapeutic activities including gardening or art, peer support and helping others.

Techniques to develop practical solutions for people with multiple conditions

Looking across the case studies we conclude four common elements, or techniques, that can help spread practical solutions that work for people with multiple conditions.



+ Many places to start

As we have looked across the case studies in this review it is clear the complexity of the challenge could actually be a help rather than a hindrance. The many different starting points – whether through an employment programme, a specific health condition, with people of a particular age, or community building in a deprived area – often lead us to people with multiple conditions. For example, the British Lung Foundation starts from a point of supporting people with lung disease but finds that 90% of the people they support have multiple conditions. Over half the people that the Black Country Steps to Work project work with have multiple conditions. As such it does not really matter where you start. Efforts to tackle the challenges of multiple conditions don't always need to start with an ambition to do that.

+ Small shifts

Many of the case studies show that small shifts to practice can make a big impact. For example, in Newcastle by making appointments for an annual health and wellbeing review in people's birthday month, putting the letter on yellow paper, and sharing test results ahead of time it helps people to prepare for the session and ultimately get more out of it. Supporting people with multiple conditions does not necessarily have to mean a complete revolution and change to what is already in place.

+ Seek external support

In many cases external funding or support has enabled people to come together to think about solutions to the challenges of multiple conditions in their area. For example, Gloucestershire and South Somerset brought about change with support from the Better Care Fund and NHS Vanguard programmes. In other examples support came from the likes of Nesta, Year of Care or an Academic Health Support Network. While there is still a lot that can be done without external support, centrally-held funds and organisations like these, local or national, can help create space and capacity for change as well as bring in new ideas about different ways of working.

+ Widen the lens and involve others

In this report we see examples of many public institutions, charities, employment services, community groups and others in the leisure, housing, arts and environment sectors doing important work to support people with multiple conditions. For example, in Luton, it is exercise trainers that are leading the way, for people with learning disabilities in the South West it is family and carers, in another example it is volunteer expert patients.

We find that tackling multiple conditions is not an issue that can, or should be, solved by health and care professionals alone. The impact of wider social, environmental and economic circumstances on the causes and effects of more people having multiple conditions is significant. And given the amount of time we spend with our families, friends, work colleagues and others compared to health care professionals we must 'widen the lens', look beyond the biomedical model of medicine, and involve a far greater number of different types of people in the effort.

The challenge and impact of multiple conditions



Why is tackling multiple conditions a complex challenge?

A number of factors combine to make tackling multiple conditions a complex challenge. Many people – academics, clinicians, practitioners and policy makers – are trying to better understand the issues around multiple conditions and why they are increasing. Much is still unknown as to the root causes but what we do know is there is 'no one problem'. The impacts from more people living with multiple conditions are widely felt but they are also unevenly distributed.

People in more deprived areas develop multiple conditions 10-15 years earlier than in more affluent ones. They are also more likely to develop multiple conditions in the first place – 28% of people in the most deprived areas have four or more health conditions, compared to 16% in the most affluent.

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Source: [Richmond Group \(2018\)](#), [Health Foundation \(2018\)](#)

MULTIPLE CONDITIONS: A COMPLEX SET OF CHALLENGES

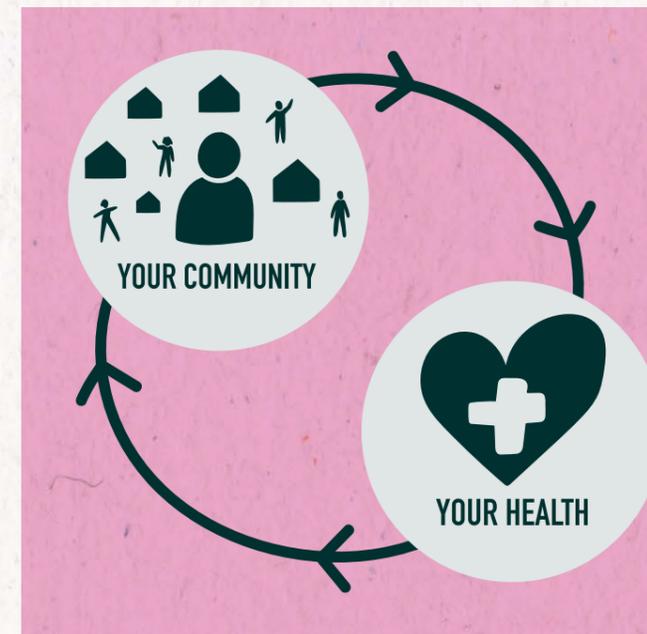


IT IS A PROBLEM FOR EVERYONE THAT BELONGS TO NO ONE

We see the impact of multiple conditions everywhere - in our public services, in our communities and in our workplaces. But the impact is most keenly felt by the millions of people living with them. Different people are affected in different ways. Some people cope fine, but for others – whether because of a lack of care and support, a system geared towards treating single conditions, or few opportunities to make the necessary adaptations - living with multiple conditions can have a severe impact on their quality of life.

Family and friends are also often affected, especially if they become one of the 5.4 million unpaid carers in England that people with multiple conditions often rely on.

The impact is felt in communities as community resilience relies on healthy residents with social connections between them. If these social connections are lost or become difficult for large portions of the community to maintain, then the strength of community reduces. This in turn makes it harder for the community to reach out and support people in need.



The impact on people

Loss of mobility, fatigue, low mood and chronic pain are common for many of those managing multiple conditions. When problems like these develop, independence can be hard to maintain. Friendships and other opportunities to socialise can fall by the wayside or be difficult to keep up. Pressure on families and others who provide care can be immense. Employment and financial security can be quickly threatened. All of this combined further affects mood and wellbeing.

Even if your overall health and wellbeing is reasonably good and you benefit from the right care and support, living with multiple conditions can still have a significant impact on daily life. On a practical level, it means more appointments and more doctors from a range of specialisms.

There are also more drugs to monitor and manage – and the greater the number of drugs an individual is on the greater the chance of complications and those drugs adversely interacting with each other.

Source: [Taskforce on Multiple Conditions \(2019\) Just one thing after another](#)



As a society the impact of more people having multiple conditions most obviously washes up on the frontline in our health and care system. NHS staff, as well as those working in care homes and other settings, are affected as the complexity of their workloads increase.

MANY SOCIAL AND ENVIRONMENTAL FACTORS COMBINE TO INFLUENCE HEALTH

THE IMPACT ON THE NHS

Figures on the impact of multiple conditions, are not collected across the NHS in England but long-term health conditions, one or more, account for:

- 50% of GP appointments**
- 64% of outpatient appointments**
- 70% of inpatient stays**
- £7 out of every £10 spent on health and social care**

Research shows that people with multiple conditions account for 1 in 3 emergency admissions, up from 1 in 10 a decade earlier.

Over a two year period, people with 4+ health conditions had nearly 30 primary care consultations, compared to ten for one condition

Source: [Health Foundation \(2018a\)](#), [Richmond Group of Charities \(2018\)](#)

Each of us faces a unique and highly personal set of circumstances, dependent on factors like where we live, the relationships we have and the work we do. As the [Marmot Review](#) on health inequalities in 2010 showed, there is undisputable evidence that the social aspects of our lives impact on our health.

Work on the social determinants of health by the [Health Foundation](#) identifies eight - our education, housing, food, money, transport, relationships, work and surroundings. The wider environment that surrounds us influences how we spend our time and our ability to do things that we know are good for health and wellbeing like eating a balanced diet, being physically active, getting enough sleep, maintaining a healthy weight, not smoking or drinking alcohol in excess.

But people, lives and the support systems around us are considerably complex. We don't yet fully understand why and how different social and environmental factors combine to increase the risk of developing multiple conditions. While we know that the risk of developing multiple conditions rises with age, this is not just a problem of old age. For example, work by [Guy's and St Thomas' Charity](#) finds over a third of people estimated to be living with multiple conditions in the London Borough of Lambeth are under the age of 65.

A DOWNWARD SPIRAL



When multiple conditions affect people's ability to look after loved ones and earn a living this can impact on other public services like housing and welfare. It is also felt by our employers and the wider economy. While difficult to quantify, estimates from the [Work Foundation](#) of the £22 billion cost of sickness-related work absence indicate the impact is likely to be sizeable. With the established link to deprivation there could then also be a downward spiral effect with worklessness further affecting health and entrenching inequalities further.

The broad impacts of multiple conditions make it as much a social issue as it is about our health. Solutions therefore need to cut across not just the NHS and social care, but also areas such as housing, transport, welfare and the voluntary and community sectors to enable greater independence, resilience and wellbeing. However these cross-cutting issues can face challenges in getting the necessary priority in policy making as they do not belong to anyone and it's not clear where ownership or accountability sits.



HEALTH CONDITIONS
AND TREATMENTS
INTERACT AND EFFECTS
ACCUMULATE

Mental and physical health conditions are often interrelated. People with multiple long-term physical health conditions are more likely to suffer with depression than those without a long-term condition. And those with mental health conditions are more likely to have poor physical health.

There are also conditions that are more likely to coexist alongside others. For example, as research by [Versus Arthritis](#) shows, almost half of people with a heart, lung or mental health condition also have a musculoskeletal condition by the age of 65. Research from the US, Germany and [Canada](#) shows that many conditions - like stroke, dementia, heart disease, and diabetes - have common underlying risk factors, such as high blood pressure, obesity and cholesterol which can cause them to cluster together.



SYSTEMS AND
EXPERTISE ARE
STUCK IN SILOS

Often professionals who want to help others find the structure of the health and care system makes it difficult. Efforts are being made to increase integration and personalisation of services in health and care. But bringing together two historically different approaches and cultures in health and social care is not without its challenge. The health system is still largely geared towards providing one-off spells of treatment and care to tackle the symptoms from disease. Social care is still largely organised around people's immediate need for care and support. Our health and care systems are often not set up to share information or work collaboratively amongst themselves, or across public services and with other sectors.

The condition-specific focus in our health system further adds to the complexity. It can make it difficult to identify people in local populations who have multiple conditions. Once identified, silos of expertise can make it hard for specialist healthcare professionals to have the full picture of a person's situation, their medical history and wider support networks.

These system and expertise silos can block an effective response to the challenge of multiple conditions as care is often fragmented and it is difficult to see the 'whole person'. This is why listening to and learning from people with multiple conditions is so important.

LOOK
AT THE

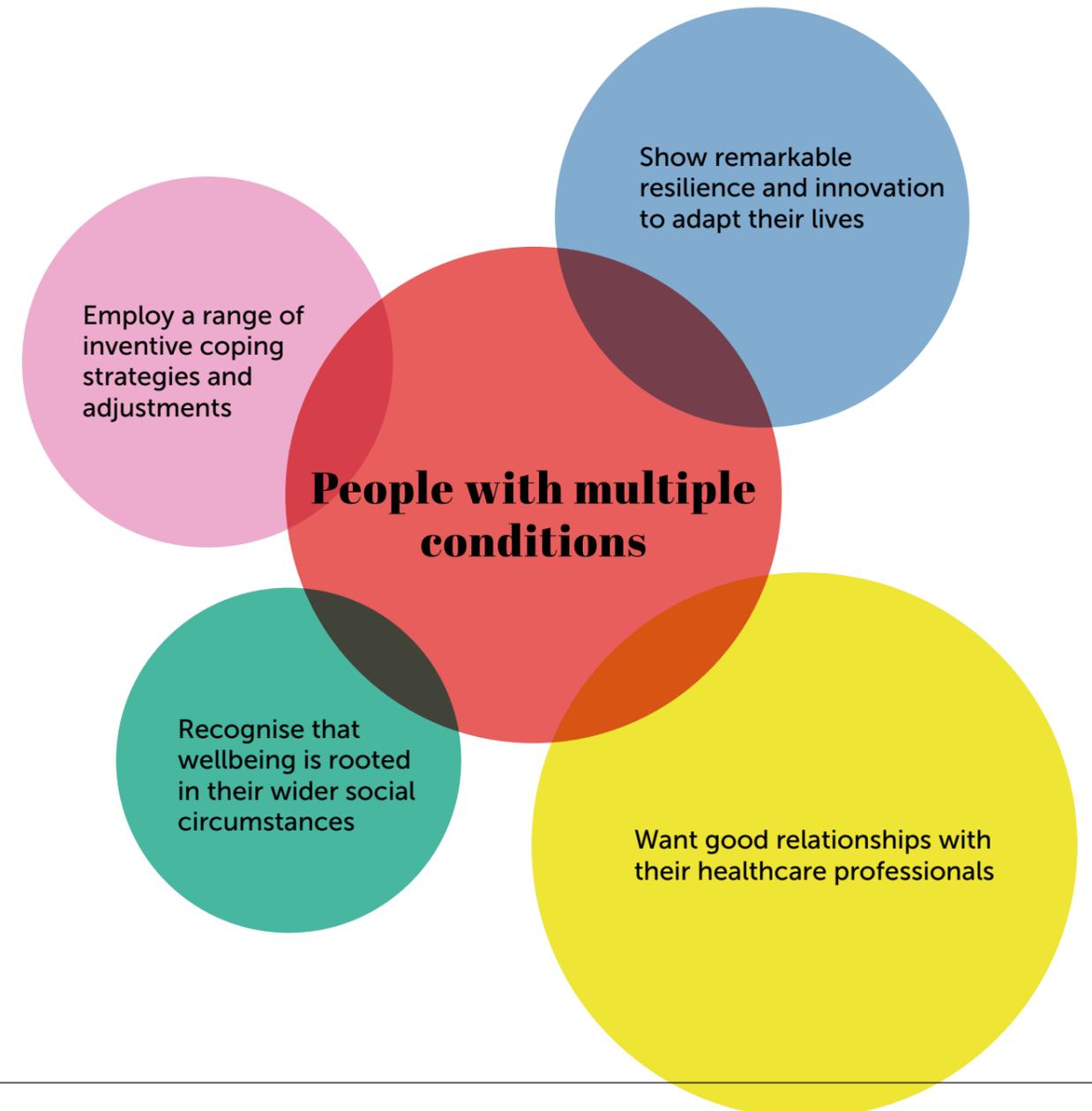


WIDER
PICTURE

Learning from lived experience

In its early work, the Taskforce found that despite academic, clinical and policy research exploring the challenge of multiple conditions, there was limited research looking beyond people's healthcare needs.

In response to this, the Taskforce's first focus was to better understand what life is like for people living with multiple conditions. Ethnographic research was published in the report called '[Just One Thing After Another: Living with Multiple Conditions](#)'. Ten participants from across England and different backgrounds took part in the research through open-ended interviews in people's homes, designed to understand their everyday experiences and quality of life. A number of video interviews were also published alongside the report. The research provides rich insight highlighting the losses and adaptations that people with multiple conditions experience and make. A selection of the findings are highlighted below illustrated by real life experiences and examples from the individuals involved in the research.





MANY PEOPLE WITH MULTIPLE CONDITIONS EMPLOY A RANGE OF INVENTIVE COPING STRATEGIES AND ADJUSTMENTS

Despite the challenges of living with multiple conditions many people adapt to be as healthy as possible and enjoy their life by employing a range of inventive coping strategies and adjustments. What is noticeable from the research is that this help isn't always medical.

One of the research participants Godfrey, for example, takes great comfort and joy in his beloved Jack Russell called Muppet. Matilda and Peter also spoke about how the routine and responsibility for feeding and caring for their pets provides a reason to keep active day to day.

In fact, nine out of 10 participants had a pet. Admittedly the sample size is small, but this seems a striking fact and suggests the power and value of looking after and having the company and comfort of an animal.

Others have developed self-described "tricks" and "hacks". Susan's husband has made several DIY home adaptations, attaching wheels to all the furniture and an extender plug socket to the wall to provide "solutions" for her.

Wendy prides herself on her intricate and personalised self-management system. Pinned up on the walls of her house and in folders in the living room Wendy had reminders of the things that make her happy, her "bliss list" as she calls it.

PEOPLE SHOW REMARKABLE RESILIENCE AND INNOVATION TO ADAPT THEIR LIVES



Several participants in the research adapted their employment to enable them to continue to work despite their changing health situations. The most notable example was Vivienne, who found herself unable to cope with her high-powered, demanding career in consultancy after becoming ill.

Instead, she became a teacher and mentor to young people looking for work. She found that, in this line of work, she was still able to practise the training and support elements of her old job without the pressure and long hours she had previously. Continuing her work also enabled her to remain focussed on the future, seeing her current job as a step in the right direction to getting her career back to what it was before she got ill.

Getting home adaptations is also important. Godfrey had a wet room fitted by "a man from the council" after his neighbour told him they'd managed to get one. He was full of praise for it, saying it had made his life significantly easier.



PEOPLE RECOGNISE WELLBEING IS ROOTED IN THEIR WIDER SOCIAL CIRCUMSTANCES – WORK, HOUSING, RELATIONSHIPS, COMMUNITY, ENVIRONMENT AND PLAY.

Others highlighted activities such as volunteering, painting, listening to music and spending time in the natural environment as also being helpful.

Keith, who is no longer able to ride his beloved motorbike or work as a cameraman and sound operator in the film industry after developing multiple conditions, now takes great joy in helping others through volunteering for Blood Bikes and describes it as the 'next best thing' to going for a ride.

GOOD RELATIONSHIPS WITH HEALTH AND WELLBEING PROFESSIONALS ARE ESSENTIAL



Another strong theme was the nature of the relationship between those managing multiple long-term conditions and their healthcare professionals. There were very positive examples described across a full range of health and wellbeing professionals, as well as examples of over-dependence or absence of engagement and distrust.

What was widely acknowledged was the value placed on continuity of care with a trusted professional, particularly with a person's GP. Keith has developed a very positive relationship with his GP. After discussing health issues they will often find time to catch up about their favourite music and new albums by bands they follow. GPs having the time for longer conversations with people like Keith is important but often a challenge in the current 10 minute appointment schedule.

Many participants seek help from a mix and variety of professions from the NHS and in the community. Vivienne finds her masseuse is a great help. She said: "After one appointment with my masseuse the pain just lifted. If I had more money I'd go and see her all the time."

In some cases, seeking out new healthcare support rather than adapting current relationships was more desirable. One such example of this was Godfrey, who struggled to trust the cancer specialists he was seeing at hospital.

He took it upon himself to research other hospitals on the internet and talk to other patients that he knew. He came across an alternative prostate team and asked to be referred. He is now much happier with the care he receives now, although he worries about others who may not have had the same idea to look elsewhere for better care.

Learning from practical experience

Ten case studies represent different settings in healthcare and communities with geographical spread across England. They detail the practical ways people with multiple conditions can live as well as possible.

Summary of case studies

Total Wellbeing Luton: the benefits of an integrated health and wellbeing services

In Luton multiple wellbeing services are integrated through a shared front door with access to things like talking therapies, smoking cessation, weight loss programmes, swimming and more. For people with multiple conditions there is a specialist team run by trainers.

Cornwall: Moving towards self-management

A public health led approach to kick start culture change, working with local partners in GP surgeries, the voluntary sector and people with multiple conditions, to co-design a range of services that encourage self-management. For people with multiple conditions there is a choice of services offered in different formats ranging from condition-specific information, personalised care and support planning, social prescribing and psychological and emotional support.

Southwark: Using navigators to organise social prescriptions

A voluntary sector-led social prescribing scheme that works in partnership with the local council, GPs and communities through a single referral checklist. For people with multiple conditions there are navigators who link them with services and activities from a menu of options. These range from formal services like talking therapies and fire safety checks to community-based activities like singing and social clubs and much in between.

British Lung Foundation: Setting up expert patient peer support groups

Sustainable and professionally supported volunteer-led peer support groups, with links to health and care services, are increasing self-management, reducing feelings of social isolation and addressing health inequalities. For people with multiple conditions, which 90% of people with lung disease have, there are monthly support groups and weekly exercise and activity groups.

South West: Helping people with Learning Disabilities

Collaborative approach to keep people with learning disabilities as healthy as possible with the promotion of prevention and training and education for carers and families. For people with multiple conditions there is a focus on ensuring opportunities for prevention – like health checks – are taken up and that the signs of deteriorating health are spotted early.

Year of Care Gateshead: GP practices combining health reviews using care and support planning

Combined annual health reviews in general practice with care and support planning driven by what matters to the person involved, their concerns and questions. For people with multiple conditions a single care plan is developed with their health care professional which can include linking people into practical support and activities in the community.

Gloucestershire: Creating a specialist multi-disciplinary community team

A multi-disciplinary community team led by community matrons including physios, dieticians, occupational therapists and wellbeing coordinators support people to stay as independent as possible. For people with multiple conditions there are medication reviews and access to activities that can benefit health and wellbeing, funded through personal budgets if eligible.

Black Country: Helping people into work

A charity-led programme to support people to help them progress closer to work, training or education with around 20 partners involved. For people with multiple conditions, over half of clients, there are links to public health and mental health providers to address their health concerns alongside employment support.

Yorkshire: Minimising the risks of multiple medications

Training for GPs to provide the confidence, tools and skills to reduce the risks from multiple medications, or polypharmacy, through de-prescribing where appropriate. For people with multiple conditions there are medication reviews and medicines stopped where there is a justifiable clinical reason.

South Somerset: Creating an enhanced team around GPs

An integrated care model involving an acute hospital, GPs, adult social care, and the voluntary and community sector with activity driven by analysis of a linked dataset. For people with multiple conditions there are more than 40 health coaches and complex care teams that work from three hubs.

Total Wellbeing Luton: the benefits of an integrated health and wellbeing service

Total Wellbeing Luton

Summary

In Luton multiple wellbeing services are integrated through a shared front door providing access to things like talking therapies, smoking cessation programmes, swimming and more. For people with multiple conditions there is a specialist team run by exercise trainers.

Main points

- There used to be two separate healthy lifestyle services as well as a provider for talking therapies
- These have been brought together by the Clinical Commissioning Group (CCG) and council public health team into one service delivered in partnership by Turning Point and Active Luton ,
- It provides a single point of access to a wide range of services
- A specialist long-term conditions team has been established within the service
- The organisation has a five-year contract from April 2018 with the option of another two years

"MY PERSONAL TRAINER ALWAYS MADE SURE I WAS COMFORTABLE AND NOT DOING SOMETHING OUT OF MY COMFORT ZONE. THIS PROGRAMME HAS BEEN AN EXCELLENT EXPERIENCE"

– SHEILA, 84, PERSON WITH MULTIPLE CONDITIONS



Context

Luton is in the county of Bedfordshire and is primarily urban. It has a population of just over 200,000 with a significant Black, Asian and Minority Ethnic community, particularly those of Asian descent.

Life expectancy is lower than the national average and the population has low rates of physical activity. It is the 59th most deprived local authority area out of 326. Around 37,000 people have a long-term condition – nearly a fifth of the local population.

"HAVING ONE POINT OF REFERRAL FOR ALL THESE DIFFERENT SERVICES IS ACTUALLY EASIER FOR BOTH PATIENTS AND HEALTH PROFESSIONALS THAN IT WAS PREVIOUSLY"

– SARAH SIMMONDS, TOTAL WELLBEING LUTON LONG-TERM CONDITIONS MANAGER

What was done?

Luton has had a range of different health and wellbeing services for people with multiple conditions for some time. There were specialist rehab services for people with cancer and heart disease which were run by Active Luton while Live Well Luton offered a range of lifestyle and weight management support. Meanwhile, East London Foundation Trust ran the local talking therapies service.

But three years ago the council and CCG decided they wanted to develop something more integrated. It led to the creation of Total Wellbeing Luton.

Active Luton is overseen by a board of trustees that include representatives from the council, CCG and voluntary sector. It partnered with social enterprise Turning Point to create the new umbrella organisation, Total Wellbeing Luton, in April 2018.

Total Wellbeing Luton acts as the front door to all the different services provided plus others like the local stop smoking service. The aim of the service is to meet the physical, social and emotional needs of the community. Partners include the British Lung Foundation, Macmillan Cancer Services, the MS Society and the Stroke Association.

Within Total Wellbeing Luton, there is a specialist team for patients with long-term conditions. The five members are all exercise rehab specialists and are level 4 qualified in specialised exercise rehab for different conditions.

The team organises support for the individuals they work with from the menu of different services that are available, tailoring programmes that meet their client's needs. That can include everything from generic services including weight loss programmes, swimming lessons and talking therapies as well as dedicated programmes, involving rehab, strength and balance exercises. There are also dedicated classes for people with long-term conditions, including Tai Chi, Pilates, dance and gardening.

To be referred into the long-term conditions team an individual has to have one of the following – cancer, stroke, mental health issues, cardiovascular disease, neurological problems and respiratory conditions. The overwhelming majority have these combined with other conditions.

The team provides intensive support for 12 weeks and this is then followed by on-going support afterwards. The classes and activities are heavily subsidised, although small contributions - £2 to £3 – are asked for.

What has been achieved?

The specialist long-term conditions team sees more than 500 people a year across the different venues, including in community and leisure centres. The impact on those individuals has been huge.

One of those that has been helped is Sheila. She is 84 and was very inactive before getting help from Total Wellbeing. She has Chronic Obstructive Pulmonary Disorder and was struggling with mobility and depression. She took part in a specialist exercise programme for people with respiratory problems. It has transformed her life. She feels good about herself and has now ditched her walking stick and is even able to climb the stairs.

She said: "I really enjoyed my sessions in the gym because all the exercises I did were always adjusted to suit me and my personal trainer always made sure I was comfortable and not doing something out of my comfort zone. This programme has been an excellent experience and I highly recommend it to anyone who require support for their health."

Luton Council public health manager Suliman Rafiq said the service is proving to be hugely beneficial for residents and is continuing to develop all the time. "It has supported hundreds of local residents. The service provides a holistic approach to a healthy lifestyle and in particular is dynamic in the emotional wellbeing services available to support residents with long-term conditions."

The data from the first year showed:

- 91%** increase in physical activity
- 75%** reduction in GP and A&E visits
- 93%** improvement in emotional wellbeing
- 84%** improvement in self-efficacy
- 90%** now achieving their 5 a day



What lessons have been learned?

When Total Wellbeing Luton was first established, there was slow uptake in referrals at first.

Health specialist manager for long-term conditions Sarah Simmonds said: "Hospital staff and GPs are busy. They were used to referring into the individual services and took some time to adapt to the new way of working.

"Looking back we could perhaps have done some more work promoting the new service in ways such as more advertising, planning earlier and more community outreach to raise awareness.

"But over time they got used to it and we are now seeing the benefits. You have to have patience – after all having one point of referral for all these different services is actually easier for both people with long-term conditions and health professionals than it was previously."

What is happening now?

The service is now two years in to a five-year contract with the option of carrying on for another two years.

Ms Simmonds said: "We want to keep improving. Engaging people from BAME backgrounds is a particular focus at the moment. We have not had brilliant uptake yet.

"We are working hard to address this. Luton is very diverse. We have been to community events and festivals and given talks at mosques. We want to help all our communities so it is important thing to do."

As well as this, the team is also constantly assessing the sort of conditions it supports. Recently it has started accepting neurological conditions, such as dementia and Parkinson's. "It is still relatively early days. We want to build on the success we have had so far," added Ms Simmonds.

"THE SERVICE PROVIDES A HOLISTIC APPROACH TO A HEALTHY LIFESTYLE AND IN PARTICULAR IS DYNAMIC IN THE EMOTIONAL WELLBEING SERVICES TO SUPPORT RESIDENTS WITH LONG-TERM CONDITIONS"

– SULIMAN RAFIQ, LUTON COUNCIL PUBLIC HEALTH MANAGER



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Southwark: using navigators to organise social prescriptions

Summary

A voluntary sector-led social prescribing scheme that works in partnership with the local council, GPs and communities through a single referral checklist. For people with multiple conditions there are navigators who link them with services and activities from a menu of options. These range from formal services like talking therapies and fire safety checks to community-based activities like singing and social clubs and much in between.



Main points

- Age UK Lewisham and Southwark appointed council-funded community navigators to coordinate social prescribing referrals
- GP-based navigators were then taken on when funding made available by CCG
- Easy-to-use checklist developed for health and care professionals to refer in – digital version produced that is compatible with the GP IT system
- Maximum of three visits per client introduced to keep waiting times down
- Navigators given time to find new groups and services to add to their menu of social prescriptions

"WE DON'T RELY ON LOTS OF PAPERWORK. WE FIND THAT CAN GET IN THE WAY... THE KEY REALLY IS GETTING TO KNOW THE INDIVIDUAL AND WORKING OUT WHAT WILL BENEFIT THEM"

– JASMINE SPARROW, PROJECT MANAGER



Context

Southwark is a densely populated and diverse inner London borough situated on the south bank of the River Thames. It includes bustling areas such as Peckham and Camberwell and leafy districts like Dulwich.

The borough of Lambeth lies to the west and Lewisham to the east. It is home to around 315,000 people and is home to the largest Black African population in the country.

The borough is ranked 41st most deprived out of 326 local authority areas. Cardiovascular disease, cancer and respiratory illness are considered the main driver behind health inequalities in Southwark.

"HAVING SOMEONE WHO IS ABLE TO NAVIGATE AND SUPPORT OUR PATIENTS HAS BEEN INVALUABLE - THE KNOCK-ON EFFECTS TO THEIR OVERALL HEALTH AND WELLBEING HAS OFTEN BEEN MASSIVE"

– DR PAYAM TORABI, GP AND SOUTHWARK CCG LEAD FOR CLINICAL EFFECTIVENESS

What was done?

A team of social prescribing navigators and a coordinator was created in 2013 in Southwark to work with the over 50s with multiple conditions. The navigators were employed by Age UK Lewisham and Southwark's SAIL (Safe and Independent Living) project under an agreement with the local council. SAIL accept referrals from GPs, hospitals and community services. It also accepts self-referrals. A year later Southwark CCG agreed to fund three GP-based navigators to work alongside the two community ones, shared between the local GP federations.

A referral checklist has been produced for local health and care professionals to fill in and refer people on. There is a paper version, although the checklist has also been incorporated into the Egton Medical Information Systems (EMIS) system used by GPs so they can complete it digitally.

It covers home safety, health and wellbeing, living conditions and income and finance, and links people in to a variety of support services in the borough. There is a menu of options, including formal services like talking therapies, fire safety checks and trading standards as well as a wide range of voluntary sector activities, such as singing, dancing and social clubs. The SAIL coordinator responds to each referral, linking the individual with all the needed services and saving them from having to chase up or make multiple calls themselves.

If someone needs support accessing social or support groups, the coordinator links in the navigators, who then meet with the individual to assess what services and groups they would be best supported to use.

The navigators can meet the individuals at the GP surgeries at their home or in community settings. Most of the time just one or two visits are needed to identify the support that is needed – although the navigators can attend groups with the individuals to get them settled if needed.

SAIL navigation and projects manager Jasmine Sparrow said: "We don't rely on lots of paperwork. We find that can get in the way. There are some screening questions that are done on the initial visits and then are followed up so we can record progress, but the key really is getting to know the individual and working out what will benefit them. "The GP navigators tend to see the more complex cases – people with at least three-long term conditions, while the community ones pick up the cases referred on from hospital as well as self-referrals and ones from other agencies."

What has been achieved?

The demand for services has grown almost every year. Between April 2018 and March 2019, SAIL received 2,200 referrals and navigators have worked with 765 clients.

The help given to Mr C is typical of the impact the service has. He is 74 and lives alone with no family nearby. He has multiple long-term conditions, including osteoporosis, arthritis and problems with his feet. He was referred to SAIL by social services. The navigator arranged for him to access talking therapies and got him a pendant alarm so he could alert services if he had a fall or needed help.

He was able to claim attendance allowance, a weekly benefit for people with frailty and disability, which he uses to pay for a cleaner, has joined a strength and balance class and regularly attends a local lunch club using the dial-a-ride service.

Another person who was helped was Mrs G. She had struggled for 15 years with little help and a chronic pain condition and had become depressed when she was referred in. The navigators worked with her to put her in touch with local groups and get her access to talking therapies. "They saw me as a human being – made me laugh. I have changed so much."

Dr Payam Torabi, a local GP and Southwark CCG lead for clinical effectiveness, said the social prescribing service is invaluable. "Having someone who is able to navigate and support our patients had been invaluable – the knock-on effects to their overall health and wellbeing has often been massive. Providing a holistic approach is at the heart of what primary care is about."



What lessons have been learned?

The pressure on services means it is always a challenge to keep waiting times down. The aim is to see people within six weeks of a referral.

Ms Sparrow says: "There are times when we get a backlog developing and we have to work really hard and do a bit of juggling. But we never turn people away."

"However, we have to be quite strict about the referrals we accept and the amount of work we do with them. We sometimes get people referred to us that actually need more intensive support from a specialist service – not just a social prescription."

"The temptation is to keep trying. It is hard to step back. But it is important for navigators to know when to refer on to other services."

What is happening now?

The GP-based navigators get the majority of their referrals from the practices they work in. However, they do accept referrals from neighbouring practices.

This is likely to grow in the coming years as the GP federation model takes hold. There are two federations in Southwark – SAIL has one navigator in one and two in another.

Time is also made to allow the navigators to explore new groups and activities to their menu of social prescriptions.

Ms Sparrow said: "Our navigators know the areas really well, but they are always on the look out for new community groups and activities they can refer on to. It is important they are given the time to develop this – we are seeing new things being added all the time."

As well as adding existing groups and activities to the menu of options, the service can also help volunteers establish new groups where there is a particular gap in the market.

The success in Southwark has also convinced Lewisham to set up a similar social prescribing system. SAIL now has five workers providing a similar service in the neighbouring borough.

THEY SAW ME AS A HUMAN BEING – MADE ME LAUGH. I HAVE CHANGED SO MUCH
 – MRS G, PERSON WITH MULTIPLE LONG-TERM CONDITIONS



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Cornwall: moving toward self-management

Summary

A public health led approach to kick start culture change, working with local partners in GP surgeries, the voluntary sector and people with multiple conditions, to co-design a range of services that encourage self-management. For people with multiple conditions, recognising there is no 'one size fits all' for self-management, there is a choice of services ranging from condition-specific information, personalised care and support planning, social prescribing and psychological and emotional support.



Main points

- Engagement events held as part of the development of the local Sustainability and Transformation Partnership to improve health and care services highlighted the need to encourage greater self-management of long-term conditions
- The council's public health team took the lead – but a great stress was placed on co-production with the public and patients
- Surveys and research carried out and a new model developed
- Various initiatives have followed, including social prescribing and a new talking therapies service with a focus on long-term conditions

"THANK YOU FOR ALL YOUR KIND SUPPORT AND UNDERSTANDING YOU HAVE INCREASED MY POSITIVITY BY 200 PER CENT"

– PATRICIA, PERSON WITH ARTHRITIS

Context

Cornwall is a largely rural county made up of a dispersed population mainly living in hamlets, villages and medium-sized towns. Around 560,000 people live in the county although the population increases in the summer because of the tourism industry.

Cornwall has average levels of deprivation, however almost 13% of the population live in what are considered to be the most deprived areas in the country. It also has an ageing population – nearly a quarter of residents are over the age of 65, which is higher than the national average.

What has been done?

It became clear during the engagement events held as part of a review of services in 2016 under the Sustainability and Transformation Partnership – an NHS England scheme to encourage local areas to develop new ways of working – that there was a need for more self-management of long-term conditions.

The council's public health team took the lead on this and working with partners the following happened from 2017:

- A regular self-management leadership group was created, involving patient representatives, the voluntary sector, commissioners and clinicians
- Four sub-groups were established covering heart disease, cancer, diabetes and Chronic Obstructive Pulmonary Disease (COPD) to gather further insight and ensure a co-production approach was adopted by including patient representatives
- Surveys of the public and voluntary sector groups were organised
- A review of evidence and a health needs assessment were carried out



What is more, there are relatively high levels of ill health. On average men spend 17 years in poor health at the end of their lives and women 19. Around one in 12 have cardiovascular disease and a similar proportion diabetes.

The findings from these activities showed that there was not a "one-size-fits-all" approach to self-management and, instead, it was important to offer a range of options and formats. For example, despite numerous promising digital developments in self-management support, 80% of respondents said they were most comfortable with face-to-face support, followed by group sessions or over-the-phone help.

It was also clear that poor health was taking its toll emotionally with 80% of respondents said they had experienced low mood, anxiety or depression related to their condition, but only 40% said they had received support for it.

This led public health to co-design a self-management model that had five clear strands:

- Peer and social support
- Personalised care and planning
- Healthy lifestyles
- Condition-specific information
- Psychological and emotional support

The model made clear these strands should ideally be available across communities and delivered in different ways to meet people's preferences whether that be in a group, individually or digitally.

What has been achieved?

Over the last year public health has been working with other partners, particularly the voluntary and community sector, to introduce some new ways of working.

A social prescribing scheme has been launched with link workers placed in 30 of the 60 local GP surgeries. More than 3,500 people have been helped so far to access activities in the community that will help them self manage their conditions. This includes things such as walking groups, dance classes and social activities.

GP practices have also started working closely with some of the existing peer support groups delivered by Diabetes UK and local community groups, while the Healthy Cornwall Service, which runs the lifestyle advice and support programmes, has been more closely aligned with practices with some advisers spending time located alongside GP staff.

Meanwhile, the Eden Project has been asked to expand some of the work it has been doing in terms of walking and horticultural groups. In addition a new service to Improve Access to Psychological Therapy (IAPT) was launched via Outlook South West for people living with certain long-term conditions – chronic pain, diabetes, heart disease and COPD.

Those who have been helped report that it has transformed their lives and allowed them to take greater control of the health and wellbeing.

The experience of Margaret is typical. She is 63 and was referred to a link worker by her GP. She has asthma and limited mobility due to osteoarthritis. Her health had begun to get her down and she was feeling isolated and depressed.

She was given financial advice – she had debt problems – and was given help to get a new boiler installed. The link worker then got her involved with a local craft group and a choir. She has begun to make friends, go out more and is feeling much more motivated and able to keep on top of things. Patricia, who is 64 and has arthritis, has a similar story. She was helped to find voluntary work at a local clothes bank, which she says has made a huge difference. “Thank you for all your kind support and understanding you have increased my positivity by 200 per cent.”

“SELF-MANAGEMENT IS NOT ONE SINGLE APPROACH. IT CANNOT BE PRESCRIBED OR PUT IN A PACKAGE LIKE A MEDICINE... IT TAKES TIME, BUT WE ARE GETTING THERE”

– RACHEL WIGGLESWORTH, CORNWALL COUNCIL



What lessons have been learned?

Cornwall has found that working with primary care networks – groups of GP practices – in local areas has been the most effective way of encouraging change rather than attempting to do things on a county-wide level.

Cornwall Council assistant director of public health Rachel Wigglesworth said: “The GPs work across 14 networks now across Cornwall and the Isles of Scilly – that has really helped to drive some of the changes on the ground.

“The local health and care system have started to value the contribution of the community and voluntary section, from organisations like Diabetes UK and MacMillan to smaller Cornwall based community organisations. For example, we have tapped into local knowledge with the social prescribing work. There are seven charities that coordinate and employ the link workers. They are the ones that know what is going on locally and what is there to help patients. That insight has been

What is happening now?

One of the next focuses in Cornwall is to develop the wider workforce. A lead coordinator within the public health team has been leading the roll out Making Every Contact Count training across a wide range of employers.

Over the last three years nearly 4,000 people have been trained via face-to-face or e-learning to improve confidence to have “healthy conversations” during everyday interactions with the public to support lifestyle behaviour change and promote self-management.

Meanwhile, clinical leaders are to undergo a health coaching training programme, which will build greater understanding of preventative approaches to help encourage culture change.

Ms Wigglesworth said: “Self-management is not one single approach. It cannot be prescribed or put in a package like a medicine”.

“It is a culture shift, with professionals moving from ‘what’s the matter with you?’ to ‘what matters to you?’, and with individuals becoming empowered and confident to manage their own health rather than rely solely on professionals. It takes time, but we are getting there.”

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British Lung Foundation: setting up expert patient peer support groups

Summary

Sustainable and professionally supported volunteer-led peer support groups, with links to health and care services, are increasing self-management, reducing feelings of social isolation and addressing health inequalities. For people with multiple conditions, which 90% of people with lung disease have, there are monthly support groups and weekly exercise and activity groups.



Main points

- Pilot in Stoke-on-Trent explored creating a more structured programme for peer support groups
- Funding through Nesta's Accelerating Ideas programme with the National Lottery Community Fund established a dedicated team to work with volunteers to create local support groups and provide training and advice for 18 months
- The British Lung Foundation (BLF) work closely with council and NHS teams in each area to bring in their expertise
- Telephone advice available once 18-month hands-on support ends
- Programme in middle of second phase of roll-out

"PEOPLE BECOME REALLY PASSIONATE ADVOCATES AND LEADERS FOR PEER SUPPORT WITH THE RIGHT SUPPORT,"

— LISA WILLIAMS, SENIOR INTEGRATED BREATHE EASY PROJECT MANAGER



Context

While mortality from heart disease and some non-respiratory cancers is falling, rates of death from lung disease haven't improved for 10 years. It is now the nation's third biggest killer.

For those living with a lung condition, daily life can be a struggle. Symptoms such as breathlessness can be frightening and difficult for people to manage alone. Everyday tasks such as walking up the stairs become a huge challenge.

People living with lung conditions are also often affected by complex health issues. Nine in 10 people

with chronic obstructive pulmonary disease (COPD) – the most common lung condition after asthma – have multiple conditions. This often causes anxiety and inactivity, causing people's health to deteriorate faster. People become socially isolated and lonely. Unfortunately, many often accept their symptoms as inevitable.

Lung disease is also a major factor in widening health inequalities. COPD is twice as prevalent in the most deprived fifth of the population as the least deprived.

**Lung conditions are one of the most common long-term illnesses.
Around 12 million people in the UK are living with lung disease.**

What was done?

Since the 1990s the BLF has been helping to establish community peer support groups for people living with lung conditions.

These groups have proved popular but can struggle to remain sustainable, have varied in style and format and have not always fully integrated into the local health and care system.

In 2011 the BLF started working with the NHS in Stoke to create a more structured integrated system of peer support, which led to the charity gaining £397,000 of funding from Nesta and the Cabinet Office's Centre for Social Action Fund for a two-year project to develop and test the Integrated Breathe Easy (IBE) programme.

The BLF set up a dedicated team to work in local areas to set up peer support groups. The three-strong team of project managers are embedded in communities working with people living with lung conditions and their carers and local health professionals to fully establish support groups over an 18-month cycle that then become self-sustainable.

The aim is to set up monthly support groups attended by speakers such as doctors and nurses along with regularly weekly exercise and activity

groups, including singing, chair-based exercise and Tai Chi to support people's holistic health and wellbeing.

Volunteer leaders, who have lung conditions themselves, are identified to run the groups and fulfil roles such as chair or treasurer. They are given training in skills such as local fundraising and booking exercise instructors and speakers and are given some seed-funding to get the groups off the ground.

Once the groups are up-and-running, they start asking for small donations from participants to cover their costs, such as venue hire, with speakers often volunteering their time for free. Some have also applied to local charitable trusts for help towards costs of additional activities, supported by BLF's fundraising team.

These groups were formerly called Integrated Breathe Easy (IBE) groups, but have recently been re-branded as BLF Support Groups. Based on the success of this roll-out, Nesta and the National Lottery Community Fund granted the BLF a further £958,309 to support a national roll-out of IBE. This is a five-year project of which the charity is in year four.

What has been achieved?

The initial two-year project saw 40 different groups set up across the UK – all of which still exist and the current national roll-out has delivered a further 46 groups. The groups are in urban and rural locations in all four constituent countries of the UK.

Group sizes ranged from 10 to 50 people. While the work is focussed on respiratory illness, the majority taking part have multiple conditions.

Feedback has been sought regularly to monitor impact. This is done when the group first starts and then six months later. It commonly shows close to 100% of respondents report their health has improved. An evaluation study by the University of Kent showed a 42% reduction in GP appointments and a 57% reduction in unplanned hospital admissions.

Meanwhile, an analysis carried out by New Philanthropy Capital in year two of the work found encouraging signs the work was addressing health inequalities. The benefits seen were greater in areas where the groups reached the most deprived people.

Overall, an evaluation of the groups set up between 2014 and 2016 found for each £1 invested there was a minimum return of £5.36 through better health outcomes, such as reduced hospital admissions. The experience of Joan, a member of the East Lothian Breathe Easy group, is typical of those who have been helped. She is 68 and has had lung cancer, which left her with scarring on her lungs. Joan also has rheumatoid arthritis.

Before joining Breathe Easy, she said she was struggling having stopped swimming, leaving her feeling isolated.



She says the group has helped her make new friends and given her the confidence to manage her condition and find out what local health services are available to help her. She is now doing a weekly Tai Chi class. "Breathe Easy takes you away from yourself. It takes your mind somewhere else," she added.

Council strategic commissioning manager for long-term conditions Sarah Crouch said: "It was a great opportunity for commissioners to work more collaboratively with people with lung conditions alongside respiratory healthcare professionals.

"Although the project has now ended, collaborative relationships continue with the Breathe Easy group volunteers. They continue to be part of the local respiratory clinical leads network and we are jointly working together to raise awareness and improve the support provided to people living with lung conditions in East Sussex."

"BREATHE EASY TAKES YOU AWAY FROM YOURSELF. IT TAKES YOUR MIND SOMEWHERE ELSE,"

– JOAN, 68, PATIENT AND PEER GROUP MEMBER



"IT WAS A GREAT OPPORTUNITY FOR COMMISSIONERS TO WORK MORE COLLABORATIVELY WITH PEOPLE WITH LUNG CONDITIONS ALONGSIDE RESPIRATORY HEALTHCARE PROFESSIONALS"

– SARAH CROUCH, EAST SUSSEX COUNCIL STRATEGIC COMMISSIONING MANAGER FOR LONG-TERM CONDITIONS

What lessons have been learned?

Having on-the-ground support for 18 months clearly helps the development of the groups. Over time the team has developed a tried-and-tested method to give them the best chance of becoming sustainable.

One of the first steps is establishing a local planning group, which brings together partners from across the local area, including carers, commissioners and health professionals. This helps to ensure buy-in from the local health economy as well as harnessing their expertise.

To act as a springboard to engaging people, the project managers organise a respiratory information event, which is promoted locally, including through GP surgery mail-outs. The events give immediate advice and support to people on managing their health and wellbeing as well as sign-posting people through to the new group meetings.

Senior IBE Project Manager Lisa Williams says: "This has been the real strength of this approach – the ability to join up with the local health system and engage people. Once you have them on board and the links established you have a good chance of having a successful group. People become really passionate advocates and leaders for peer support with the right help.

"But we also make sure we provide them with on-going support. Towards the end of the 18-month cycle, the project managers start pulling away gradually. But when they have left the peer leaders can still access a central support team for telephone advice."

What is happening now?

To help build on this on-going support, an online forum has recently been launched. Group volunteers are given login details, which they can use to access bespoke training modules, advice and guidance, and a forum to share experiences with other groups across the nation. This is allowing peer leaders to share ideas and ask questions of others involved in the work.

The work of the team is also continuing. The BLF is now preparing to expand into new areas, using what they've learned throughout the project. The aim is to carry out another evaluation of the work to help build the evidence-base for it.

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South West: helping people with learning disabilities

Summary

Collaborative approach to keep people with learning disabilities as healthy as possible with the promotion of prevention and training and education for carers and families. For people with multiple conditions there is a focus on ensuring opportunities for prevention – like health checks – are taken up and that the signs of deteriorating health are spotted early.



Main points

- Two clinicians championed the needs of people with learning disabilities, helping to set up a collaborative group of local partners across Bristol, North Somerset, South Gloucestershire, Swindon, Wiltshire and Gloucestershire
- Conference held and priority areas established, including helping to spot signs of deterioration and keeping people well
- Steering group established to drive forward the work
- Partners now making progress, training families in how to monitor deterioration and encourage people with learning disabilities to come forward for flu jabs and health checks

Context

There are around 1.5m people with learning disabilities across the UK. They face significant health inequalities.

Around one in three people with a learning disability die from potentially avoidable causes, compared to one in 11 of the general population.

Major factors behind this include not acting early enough when patients deteriorate and failing to diagnose and therefore manage long-term conditions – rates of obesity, diabetes, coronary heart disease and epilepsy are all higher.



The average age of death of someone with a learning disability is 60 for men and 59 for women – that is more than 20 years earlier than the average.



What has been done?

Improving care for people with a learning disability is one of the key priorities of NHS England's long-term plan published in early 2019.

Some key personnel in the south west region had started to think about what more could be done to help this vulnerable population.

The West of England Academic Health Science Network (AHSN) had already helped to roll out the National Early Warning Scores (NEWS) tool across the health system including to acute hospitals, primary care, mental health, community and ambulances services. The tool is traditionally used by hospital doctors and nurses to help spot the early signs of deterioration by monitoring breathing, oxygen levels, blood pressure, heart rate and temperature.

It had improved outcomes for patients across the region so the network wanted to see if this could be used to improve care for people with learning disabilities specifically.

West of England AHSN primary care clinical lead Dr Alison Tavare had had personal experience of the challenges people with learning disabilities face. Her nephew, Toby, has profound learning disabilities. A few years ago he was admitted to hospital with abdominal pain. It was very challenging he was unable to say what was happening. Eventually he had an operation for a ruptured appendix.

After that Dr Tavare was involved in raising awareness of NEWS so she decided to teach Toby's parents how to use the system. In 2016 Toby became very unwell again and after using NEWS his mother took him into hospital saying she thought he had sepsis. She was right and potentially saved his life.

Meanwhile, Kevin Elliott, NHS England's lead nurse for learning disabilities for the south west, with others in his team had been championing improvements in local services for some time. When Dr Tavare contacted him to see if they could work together, he immediately agreed.

They decided to set up a collaborative group, incorporating people with lived experience, local social care teams, hospitals, GPs, families and carers. A host event was held in Bristol and more than 130 people attended from Bristol, Gloucestershire, Wiltshire and North Somerset.

The conference identified three key priorities:

- Increasing uptake of flu vaccinations
- Increasing uptake of health checks
- Improving the ability of social care and families to identify the signs of deterioration

A steering group, composed of key partners chaired by Dr Tavare and Mr Elliott, was established to drive forward the work and an online forum was set up to help partners share ideas and good practice.

Mr Elliott says: "People with learning disabilities face many barriers to achieving equal health outcomes compared to the rest of the population. They face greater disadvantages in terms of social determinants, such as housing, health literacy and social isolation.

"What is more, services are not always geared up in a way that makes them easy to access and quote often they rely on others to help them.

"It means they are not getting the preventative care they need to keep the well. Around half of people with long-term conditions fail to attend their annual health checks and even more do not get their flu vaccinations."





What has been achieved?

A number of different projects are now beginning to get off the ground. In Gloucestershire the Clinical Commissioning Group (CCG) has been working with local social care teams to introduce a telehealth project whereby carers take blood pressure, pulse and respiratory readings.

The local parents forum has been tasked with doing some communications around take up of the annual health check. This is likely to include some postcards spelling out the importance of the checks and how to make sure people with learning disabilities get them.

Organisations across the region which support people with learning disabilities have formed a focus group to find out what is being done well and what could be done better. They are sharing ideas and resources. Some are really simple such as ensuring that people with learning disability are sent letters about flu immunisation in Easy Read format. These ideas and resources are being collated into a series of toolkits and activities to be shared across the region.

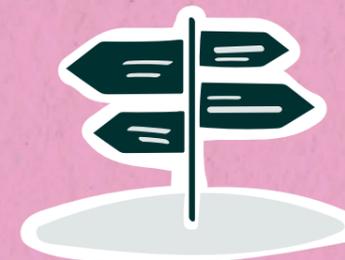
Meanwhile, a specialist community learning disability team has commenced training workshops for care staff, families and carers about spotting the signs of deterioration using NEWS.

Dr Tavare said: "Using NEWS as a common language across the NHS, from the GP surgery, to the ambulance service, to the emergency department and into the hospital has improved outcomes for the general population.

"We hope that by working together across the region we can similarly use NEWS as a common language to help quickly identify when people with learning disability are unwell and then use it to communicate with other teams to enable prompt treatment."

"WE HAVE BEEN OVERWHELMED WITH THE ENTHUSIASM AND SIGN UP OF SO MANY PARTNERS ACROSS THE HEALTH AND SOCIAL CARE SECTORS AS WELL AS FROM EXPERTS BY EXPERIENCE AND FAMILY CARERS"

– KEVIN ELLIOTT, NHS ENGLAND'S LEAD NURSE FOR LEARNING DISABILITIES FOR THE SOUTH WEST



"WE HOPE THAT BY WORKING TOGETHER ACROSS THE REGION WE CAN SIMILARLY USE NEWS AS A COMMON LANGUAGE TO HELP QUICKLY IDENTIFY WHEN PEOPLE WITH LEARNING DISABILITY ARE UNWELL AND THEN USE IT TO COMMUNICATE WITH OTHER TEAMS TO ENABLE PROMPT TREATMENT"

– DR ALISON TAVARE, GP

What challenges have been overcome?

Some concerns have been expressed that NEWS can be too complicated for non-clinical people to use, requiring knowledge and judgements to be made.

Therefore, the collaborative have been working with West Hampshire CCG and Wessex Academic Health Science Network as they have produced a package called RESTORE2.

RESTORE2 has been used in care homes by paid carers. It starts with the idea of "soft signs" such as someone becoming much more quiet than usual and worrying the carers who know them well.

After training the carers are then shown how to measure NEWS and use this to talk to others about why they think someone could be unwell. It is at the early stages, but staff say they feel empowered so the team want to see if it can be spread to other care homes and if outcomes can be improved.

The collaborative believe this could be a useful way of helping care staff, families and carers of people with learning disabilities alongside the use of NEWS and are aiming to trail its use with care staff.

What is happening now?

The project is due to run until the end of summer 2020. Then, at the end of the programme of work, the steering group will carry out a formal review of what has worked.

Mr Elliott said: "We have been overwhelmed with the enthusiasm and sign up of so many partners across the health and social care sectors as well as from experts by experience and family carers. It is presenting a challenge in finding the capacity and resources to support all of the innovations.

"NHS England and Improvement has committed funding from the regional learning disability programme budget, however, this is finite. The collaborative is looking to other funding streams to support the work. That said, much is being achieved without funding, simply in bringing partners together across the whole health and care system."

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Gloucestershire: creating a specialist multi-disciplinary community team

Summary

A multi-disciplinary community team led by community matrons including physios, dieticians, occupational therapists and wellbeing coordinators support people to stay as independent as possible. For people with multiple conditions there are medication reviews and access to activities that can benefit health and wellbeing, funded through personal budgets if eligible.



Main points

- Multi-agency project group set up to look at what could be done to improve care of people with multiple conditions as part of the push for integrated care
- Funding provided by the Better Care Fund
- Complex Care @ Home team established in April 2018 in two areas
- Use of a risk stratification tool developed with GPs so they can identify people on their registers who may benefit from the service
- Service rolled out to third area in April 2019

STRENGTH

IN

NUMBERS



Context

Gloucestershire is in the south west of England and is home to around 630,000 people. There are more than 30 towns and one city, although large parts of the county are rural.

The county overall has an older population when compared with the national average and lower than average percentage of Black, Asian and Minority Ethnic communities.

It has pockets of deprivation, but overall the population is pretty affluent with the county ranked as the 124th most deprived out of 152 upper tier local authority areas.

Rates of ill-health are highest in Gloucester and Cheltenham and the district of Forest of Dean.

What was done?

With funding available through the Better Care Fund, the authorities in Gloucestershire decided they wanted to create a new model of care to help people with complex health conditions better manage their own health and wellbeing.

A multi-agency project group was set up including representation from primary care, adult social care, the mental health trust, community provider, commissioners and the commissioned carer organisation.

A combination of desktop research, data analysis and a stakeholder event for health and care professionals informed thinking and in April 2018 a new Complex Care @ Home service was launched in Gloucester and Cheltenham.

The service – run by Gloucestershire Health and Community Services, the provider of community NHS services – incorporates eight community matrons, two dementia matrons, two wellbeing coordinators, two occupational therapists, two physiotherapists, a dietician and two adult social care navigators.

People are proactively identified from primary care and the team also receive referrals from other



“THE KEY AIM OF THE MODEL IS TO PROACTIVELY IDENTIFY PEOPLE AT RISK OF DETERIORATION AND PROVIDE A WRAP-AROUND SERVICE TO ENABLE THEM TO BETTER MANAGE THEIR HEALTH AND WELLBEING TO REMAIN LIVING AT HOME FOR AS LONG AS THEY ARE ABLE”

– CHRISTINE CAM, SENIOR COMMISSIONING MANAGER

health and social care sources, including the acute hospital. The team work with people with long-term conditions, frailty and dementia. Most of these people are losing their resilience due to a number of health and social factors.

The community matrons carry out a person-led assessment with the individual, known as “What Matters to You”, which establishes the goals the person aims to achieve. The matrons address any medical needs including medication reviews. They are often accompanied on visits by an adult social care navigator who helps to find solutions for low level social care needs.

The wellbeing coordinators then work alongside the person enabling them to achieve the goals set out in their plans. This can involve a wide range of activities and includes getting involved in local groups, improving physical activity or helping people plan ahead in order to re-engage with society where people have become socially isolated.

The wellbeing coordinators work closely with the voluntary and community sector and the Community Wellbeing Service so they are well placed to link people to support networks in their local communities.

What has been achieved?

The service has now worked with over 800 people and is currently being evaluated. Early findings suggest a range of benefits for individuals receiving the service including improvements in mobility, the management of health conditions and access to local resources such as community cafes to reduce social isolation and improve wellbeing. Analysis of data to date illustrates a positive impact on the demand for primary care services. Further work is underway to establish the impact on other areas of the health system.

The case of Mrs B is a perfect example of what can be achieved. She has type two diabetes, hypertension, chronic pain and anxiety. She was on 10 medications and never left the house. Her medicines were reviewed and reduced and she was given access to a personal budget to fund a personal trainer to start physical activity and motivate her. She soon joined a gym and also started going to a local coffee morning and "Knit and Natter" group. In the space of a few months she lost 10kg and started gardening.

Another person who has been helped is Dave. He has heart problems and ended up in hospital earlier this year after an accident at home.

He said their support helped him retain his independence and stay at home. "They are always there in the background to help. For people like me that is so important."

Gloucestershire senior commissioning manager for integrated commissioning Christine Cam says: "Our focus is on people who are at risk and beginning to lose their resilience and independence.

"The real benefit of the team is that they can take a holistic approach with clinical and social care input focusing both on health and wellbeing. The wellbeing coordinators play a vital role in enabling people to fulfil their goals and access low level community support to sustain the benefits achieved.

"One of the aspects which is really important is the support we provide to get involved with activities that can benefit health and wellbeing. For example, the wellbeing coordinators can book them in and sometimes even attend the first few sessions of a Slimming World group or exercise class. The ultimate aim is to keep people at home and active by maintaining their independence and, where possible, reversing decline."



"IT IS REALLY FULFILLING WHEN YOUR PATIENTS TELL YOU YOU HAVE CHANGED THEIR LIFE AND THEY ARE IN A DIFFERENT PLACE"

— LISA TALEB, COMMUNITY MATRON

What lessons have been learned?

In the early days of the service some of the referrals were for people whose needs were greater than intended by the model. The opportunities to prevent deterioration and increase self-management of conditions were therefore not always as possible as envisaged.

To help tackle this, a tool was developed that GPs could use with their own IT systems to identify the people who would most benefit from the support. The risk stratification tool uses set criteria to choose people from the GP register that are most likely to benefit. It includes the requirement that people are over 18, have three or more long-term conditions and are on five or more medications. Having an unplanned hospital admission, a fall or being housebound are also triggers.

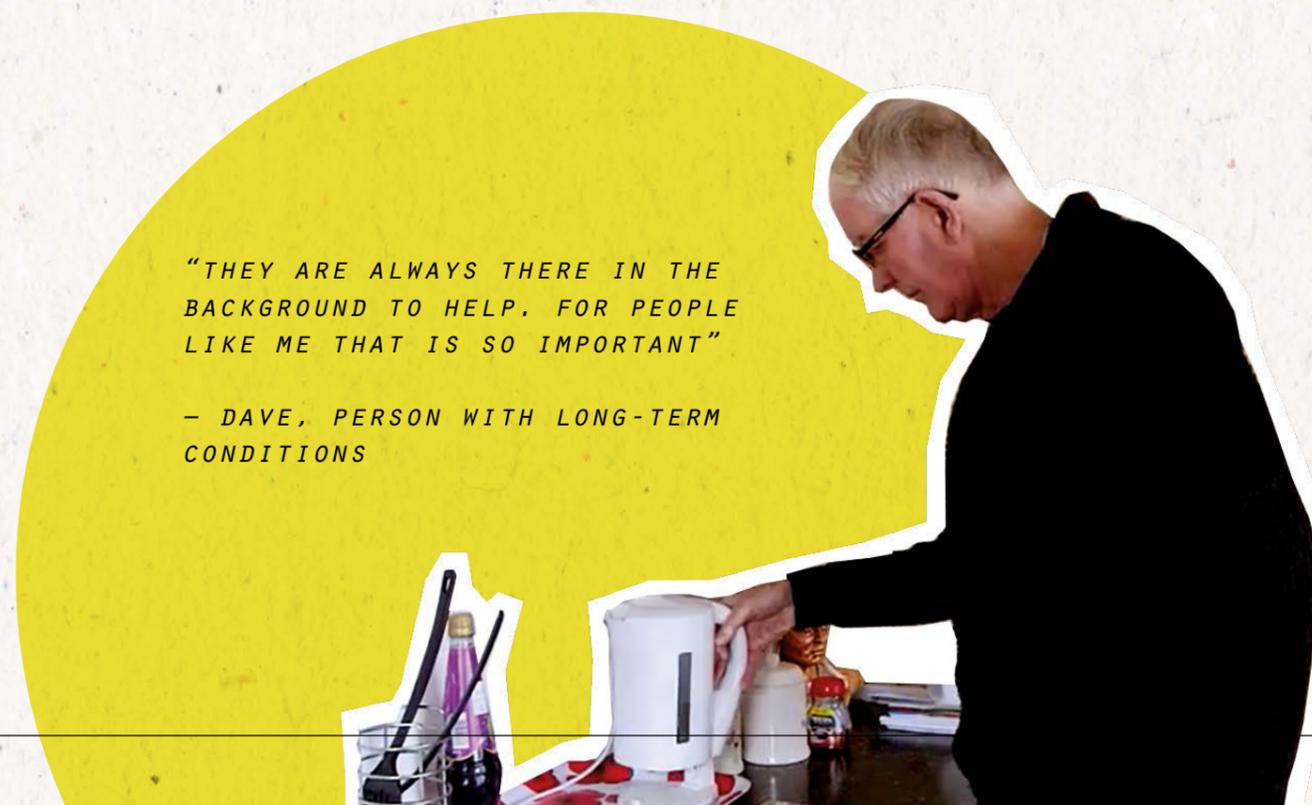
The use of the tool and further engagement with primary care and other partners resolved those early problems and the cohort of people receiving the service is now as was intended in the original service modelling.

What is happening now?

Following on from the success of the work in Gloucester and Cheltenham, a Complex Care @ Home service has been launched in the Forest of Dean. This means all three areas of the county with the highest levels of ill-health now have the service. Community matron Lisa Taleb said that is making a huge difference. "The idea is that people will take control of their lives, become more independent and manage their long-term conditions more effectively.

"It is really fulfilling when your patients tell you you have changed their life and they are in a different place. It is great to know we have improved their quality of life."

The service has now been operating for over a year and is currently being evaluated further to establish the outcomes that have been achieved with people and the impact of the service across the wider system. There are plans to further develop the model in response to the findings of the evaluation.



"THEY ARE ALWAYS THERE IN THE BACKGROUND TO HELP. FOR PEOPLE LIKE ME THAT IS SO IMPORTANT"

— DAVE, PERSON WITH LONG-TERM CONDITIONS

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Yorkshire: minimising the risks of multiple medications

Summary

Training for GPs to provide the confidence, tools and skills to reduce the risks from multiple medications, or polypharmacy, through de-prescribing where appropriate. For people with multiple conditions there are medication reviews and medicines are stopped where there is a justifiable clinical reason.



Main points

- Yorkshire and Humber Academic Health Science Network Improvement Academy, one of 15 such networks set up to promote innovation in the NHS, partnered with Harrogate and Rural District CCG
- Training workshops offered to local GPs – staff from 12 practices take part
- GP practices supported to carry out medicine reviews, using STOPP/START tool to identify patients who needed to be prioritised
- Medicines were successfully reduced in Harrogate. Mass project now underway with South Yorkshire and Bassetlaw Integrated Care System expected to work with nearly 200 GP practices
- Other AHSNs across the country are following Yorkshire and Humber's lead and applying the learning from Harrogate



"I FEEL SO MUCH BETTER, I CAN GARDEN NOW, I'M NOT DIZZY ANYMORE"

– PERSON WHO BENEFITED FROM MEDICATION REVIEW

Context

The ageing population has led to increasing numbers of people living with frailty. Approximately 10% people over the age of 65 have frailty. That increases to up to half of people over the age of 85.

Alongside frailty, these people often have a range of other long-term conditions and, as a result, take many medications. This is known as polypharmacy.

Research suggests around a fifth of medication being taken by older people outside of hospital is considered inappropriate because it is either ineffective or puts people at risk because of complications with other medications they take. This increases the risk of adverse drug reactions and hospital admissions. Individualised medication reviews are therefore important.

What was done?

Harrogate and Rural District CCG contains 17 GP practices and serves a population of around 160,000 people. Many are older people - 22% are aged over 65, which is higher than the national average.

In 2017 Harrogate and Rural District CCG medicines management team worked in partnership with Yorkshire and Humber AHSN's Improvement Academy, a team of improvement scientists, patient safety experts and clinicians funded by the Health Foundation, to look at how GPs could be encouraged to carry out medicine reviews on those patients who were taking multiple medications. Invitations were sent out to local GP practices to take part in the project – and 12 practices agreed to take part.

Members of the GP practice staff took part in four workshops run by staff from the Improvement Academy. These covered talks from a pharmacist and geriatrician about the importance of medicine reviews and how to go about them along with videos and presentations by patients.

The workshops also covered the NHS Scotland polypharmacy guidelines, which detail in what circumstances commonly prescribed medicines may not be effective and how different drugs can interact with others.

"THERE IS GROWING CONCERN ABOUT INAPPROPRIATE POLYPHARMACY, BUT WE KNOW GPs DO NOT ALWAYS FEEL CONFIDENT TO BE ABLE TO ADDRESS IT...

THIS PROJECT AIMED TO PROVIDE THE GPs WITH THE RESOURCES, SUPPORT AND TOOLS TO ENABLE THEM TO MANAGE THIS WITHIN THEIR PRACTICE"

- KHALIDA RAHMAN, YORKSHIRE AND HUMBER AHSN PROGRAMME MANAGER

In between the workshops the project team spent time with each practice to help identify patients who should be prioritised for a medicines review.

The target population was the over 85s who were on at least 15 medications and had severe frailty. The data was extracted using searches of the GP clinical records using the STOPP/START software. This enabled the GP practices to carry out scores of reviews over the course of 24 weeks.

Yorkshire and Humber AHSN programme manager Khalida Rahman said: "There is growing concern about inappropriate polypharmacy, but GPs reported that they did not feel confident to have conversations with patients around stopping medicines and feared the consequences of doing so.

"Polypharmacy is now a national priority, but many long serving GPs may not have received training in this during their early careers as a GP. This project aimed to provide the GPs with the resources, support and tools needed to commence conversations around stopping medicine within their practice."



What has been achieved?

The practices saw a 6% reduction in the number of medicines being prescribed during the project. The research showed an average of 1.05 medicines were stopped per review, providing an annual average saving of £69.

The evidence suggested medicines were being stopped for justifiable clinical reasons, including duplication, ineffectiveness and safety.

Patients reported they had seen a significant impact. One said: "I feel so much better, I can garden now, I'm not dizzy anymore." While a wife of one patient said: "You've hit the sweet spot... I've got my husband back."

Dr Jackie Aitken, one of the GPs who took part, said their initial concerns about the idea of de-prescribing were soon allayed.

"When we started we didn't think we would have the knowledge or language to explain to the patient why we were offering to stop certain medications, particularly when they may have been prescribed initially by a consultant. I'm a GP. I didn't think it was my place. But when we got started the patients seemed eager. It was more simple than we thought it would be."



"I'M A GP. I DIDN'T THINK IT WAS MY PLACE. BUT WHEN WE GOT STARTED THE PATIENTS SEEMED EAGER. IT WAS MORE SIMPLE THAN WE THOUGHT IT WOULD BE"

– DR JACKIE AITKEN, GP

What lessons have been learned?

The design of the programme involved significant investments of time on all sides. While 16 GP practices started the workshops, only 12 remained involved all the way through.

Ms Rahman said: "Due to work constraints, GPs are under pressure and may find it difficult to take time out of practice to participate in additional projects therefore it is important to get the right balance between providing them with the necessary support and tools to manage polypharmacy without making it too time-consuming to put them off participating."

"You also need to think carefully about how you engage patients around the topic of polypharmacy and the associated risks. It is one thing getting GPs on board, but if patients are not willing to consider reducing the number of high-risk medications they take then it is not going to have the positive impact it could have."

"Engagement with patients who have been identified as a higher risk group is being built in to our communication strategies."

What is happening now?

Following on from the success of the project in Harrogate, Wessex AHSN, which covers Dorset, Wiltshire, Hampshire and the Isle of Wight, ran a similar exercise for its GPs.

Meanwhile, in the Yorkshire and Humber region South Yorkshire and Bassetlaw Integrated Care System has been identified as the next area to focus on. But the project – due to start in October 2019 – will be on a larger scale.

It will involve nearly 200 practices and will, therefore, be run differently. This time Yorkshire and Humber AHSN plan to run one large workshop with a follow up later on.

The lead prescribers across the region will also receive training in de-prescribing and encouraged to cascade that knowledge across their colleagues.

Yorkshire and Humber AHSN medicines optimisation programme lead Gareth Durling said: "We are looking at a whole health economy this time. That will be a challenge as it is quite different from the more intensive, relatively small-scale work we did previously."

"But it will be vital to see how it works. As we move to integrated care systems in the NHS we need to see how we can encourage and support large-scale change."

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Year of Care Gateshead: GP practices combining health reviews using care and support planning

Summary

Combined annual health reviews in general practice with care and support planning driven by what matters to the person involved, their concerns and questions. For people with multiple conditions a single care plan is developed with their health care professional which can include linking people into practical support and activities in the community.



Main points

- Started to re-think approach in 2013 and CCG published a new long-term conditions strategy
- Worked with Year of Care Partnerships which provided expertise and resources and then trained staff and directly supported practices to adopt the approach
- Project manager appointed, clinical lead identified and steering group set up including supporting a patient reference group
- Joint funding from the CCG and British Heart Foundation helped seven early adopter GP practices get started in 2014
- Work now extended across Newcastle and Gateshead

Context

Gateshead is located on the southern bank of the River Tyne, directly opposite Newcastle. The borough stretches almost 13 miles along the south bank of the River Tyne and covers 55 square miles. Just over 200,000 people live in Gateshead.

It is the 73rd out of 326 most deprived local authority in England. Deprivation is concentrated in the urban parts of central and east Gateshead. There is a small ethnic minority population, largely based

in central Gateshead, but their age profile is young, with low reported levels of obesity and other risk factors for diabetes. Central Gateshead is also home to a large and long-established Jewish community.

In Gateshead, two in every three adults carries excess weight and one in four are obese. There are higher rates of cardiovascular disease, diabetes and respiratory illness than the national average.

Year of Care Partnerships

Year of Care Partnerships is an NHS organisation, based within Northumbria Healthcare NHS Foundation Trust.

It was set up to offer commissioners and providers expertise, practical support and training to embed care and support planning as a more personalised way to deliver care for people with living with long-term conditions.

Developed in a pilot programme using diabetes as an exemplar, Year of Care Partnerships has now worked with over 40 communities to introduce care and support planning for people with long-term conditions.

What is care and support planning?

Care and support planning (CSP) is a way of changing routine annual reviews in general practice to ensure that the discussion is based on what is important to each person in living their life with long-term conditions.

It moves away from a tick-box approach and replaces it with a genuinely patient centred conversation bringing together what matters to the person and the technical expertise of the professional. Routine test results and a prompt to identify topics to talk about are sent to patients ahead of the session so they can prepare.

It often ends up focusing on solutions that link to community support or better coordinated care for people who may be attending multiple medical appointments. Issues, previously discussed in separate visits, are brought together into a single review process no matter how many conditions the person may live with.

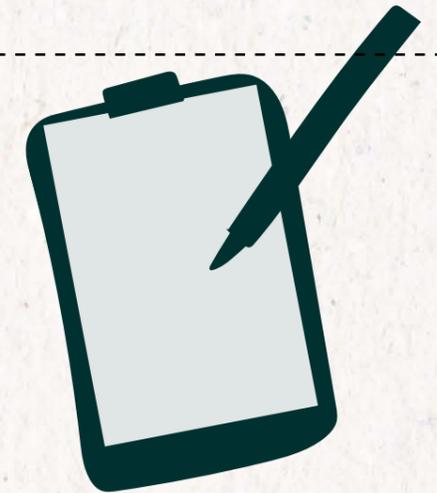
What was done?

Gateshead CCG started to rethink its approach back in 2013 with leadership from Dr Steve Kirk, Clinical Director for Delivery. A new long-term conditions strategy recognised that living with multiple conditions was becoming increasingly common and it wanted to place a greater emphasis on self-management and move away from treating people in disease silos.

In 2014 the CCG successfully applied to take part in the British Heart Foundation House of Care project. This three-year feasibility study aimed to transfer the learning about CSP in diabetes to people living with cardiovascular disease.

It was rapidly identified that many people had other long-term conditions and the concept of a combined annual review process for those living with multiple conditions was adopted.

A steering group was established with representatives from the CCG, Year of Care Partnerships, GP practices, voluntary sector representatives and public health. A patient reference group was also established to co-produce the project and a full time project manager appointed.



Year of Care Partnerships provided CSP training for practices. This involved an introductory day followed by a reflective half day some six weeks later.

Six practitioners were also trained as Year of Care trainers to champion the work and build local capacity and local clinicians developed disease-specific master classes for practice nurses and GPs to improve confidence in long-term conditions management.

Regular "Time Out" sessions involving all practice staff from the receptionists and admin assistants to GPs were used to ensure everyone was aware of the new approach and could answer any questions patients had.

What has been achieved?

As part of the evaluation of the feasibility study, 190 patients were surveyed. It showed:

- 94%** found the preparation letter 'useful, 'or somewhat useful'
- 87%** rated the care and support planning conversation as "very good" or "excellent"
- 81%** were better able to understand their conditions
- 75%** were better able to cope with their conditions
- 71%** felt more able to self-care

It also found clinical processes such as blood pressure measurement were recorded more reliably and staff reported their skills and understanding of the challenges faced by those with multiple LTCs had improved.

Feedback from individual patients has been positive too. One said it helped them really understand their conditions whereas before they had felt "kept in the dark". Another said previously the reviews had seemed too focused on medicine whereas now there was "time to talk" and draw up strategies to improve their health and wellbeing.

Dr Rebecca Haines, the CCG's clinical lead for diabetes and GP partner at Glenpark Medical Practice, which was one of the early adopters, said: "The new approach has really made a difference to the way we work - it seems to have made it easier for patients to become more actively involved and talk about what matters to them.

"It is all about getting patients prepared for the annual review – we find it gets them thinking about what they want to discuss and that helps us make the most of the review."

Moving away from single disease reviews has also been important. Dr Haines said: "For example, there was one patient who had been coming for his diabetes review for years. It was only when we started doing care and support planning that he mentioned the thing he wanted to talk about was pain.

"He had come to see a doctor a few years ago and was told it was just wear and tear and nothing could be done. He had not bothered to mention this again despite worsening symptoms and by then had quite advanced osteoarthritis. We were able to help and support him much better from that point on."

"THEY'RE A REAL BEACON. THEY HAVE PUT THE RIGHT STRUCTURES IN PLACE IN TERMS OF SUPPORT AND TRAINING, WHICH HAS MADE IT MUCH EASIER FOR PRACTICES TO CHANGE THE WAY THEY WORK AND SUSTAIN IT"

– LINDSAY OLIVER, YEAR OF CARE PARTNERSHIPS NATIONAL DIRECTOR



"THE NEW APPROACH HAS REALLY MADE A DIFFERENCE TO THE WAY WE WORK - IT SEEMS TO HAVE MADE IT EASIER FOR PATIENTS TO BECOME MORE ACTIVELY INVOLVED AND TALK ABOUT WHAT MATTERS TO THEM."

– DR REBECCA HAINES, GP

What lessons have been learned?

The work of the early adopters has taught Gateshead several key lessons, particularly in terms of preparing for the care and support planning combined review.

People are invited for a review in their birthday month, making it far easier for everyone to remember when it is due. People initially attend an information gathering appointment where a healthcare assistant completes a range of tests and assessments at a single appointment for all the conditions the person lives with.

This then allows for the important step of preparation - people are sent a pack including their routine test results, which includes depression screening and asks people to identify issues that are impacting on their health, such as housing and loneliness.

The idea is that people can have a think about the things they wish to discuss and have the same information as the doctor or nurse. This gets sent to people one to two weeks before the care and support planning conversation.

In one of the practices the admin team thought it would be a good idea to send this preparation prompt on yellow paper so that it would be easy to distinguish from other pieces of information. This proved popular and people often now talk about their "yellow letter".

The care and support planning appointment allows a little more time for a discussion based on the concerns and questions that the patient has. It brings together traditional clinical issues with what is most important to the individual as well as creating an opportunity to think about the ways in which people can manage their own health and be supported to live well with their multiple conditions. The aim is to create a single care plan no matter how many conditions the person lives with - and this can include linking people to practical support and activities in the community through social prescribing link workers.

What is happening now?

The initial project lasted three years, running from 2014 to 2017. During this time Gateshead CCG merged with Newcastle CCG and work is under way to roll out the work across general practices in both areas using incentive payments. So far 59 out of 63 local GP practices are taking part.

Practices are also increasing the number of long-term conditions they include, extending it to involve people living with ageing and frailty and, in some places, people living with musculoskeletal conditions.

Year of Care Partnerships national director Lindsay Oliver says the work done in Newcastle and Gateshead has been "magnificent". "They're a real beacon. They have put the right structures in place in terms of support and training, which has made it much easier for practices to change the way they work and sustain it."

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Black Country: helping people into work

Summary

A charity-led programme to support people to help them progress closer to work, training or education with around 20 partners involved. For people with multiple conditions, over half of clients, there are links to public health and mental health providers to address their health concerns alongside employment support.



Main points

- Local charity Steps to Work applies to European Social Fund and National Lottery Community Fund for funding
- New programme set up tapping into the skills of multiple local partners, including NHS, local councils and voluntary sector
- Referrals are managed by project officers who organise support to help people move towards employment
- Programme set targets to ensure those with physical and mental health conditions are helped
- Programme given three-year extension to 2022 following success

"I HAVE HAD SUPPORT BEFORE, BUT NEVER WITH A SUCH A CARING APPROACH. NOTHING IS TOO MUCH. THANKS TO THE APPROACH TAKEN, I HAVE STARTED TO REALISE MY POTENTIAL"

– THOMAS BEALE, CLIENT

Context

The Black Country covers an area to the west of Birmingham, taking in the metropolitan boroughs of Walsall, Wolverhampton, Dudley and Sandwell. The name is thought to come from the soot from the heavy industries that defined the area in the 1800s, including coal mining, brick-making and steel works.

Following the decline of those industries, the area suffered high rates of unemployment. Even today finding work can be difficult for some with the area having some of the most deprived neighbourhoods in the country.

The economic situation has seen a number of different organisations spring up to support people into work. One of the most established is Steps to Work, a charity which was formed in the late 1990s and has worked with over 30,000 people.



What was done?

People with long-term conditions can face multiple barriers to gaining employment. The health conditions themselves can make it more difficult to find work or may have meant individuals have no longer been able to carry on working in the job they used to do.

The charity Steps to Work applied to the Building Better Opportunity Programme for funding to provide one-to-one support to over 24s with complex needs. The programme is funded by the European Social Fund and National Lottery Community Fund.

The vision was to create a programme of support that tapped into local partners from the NHS, local government and voluntary and community sectors. Bridges (Building Reachable Individual Dreams Gaining Employment and Skills) was launched in July 2016 with 28 delivery partners on board, offering a diverse range of services and activities. It is led by Steps to Work who then have contracts with the individual partners.

Each delivery partner has their own team of staff working on Bridges. Across the partnership there are 85 staff in total working within the community supporting people and an additional 44 offering administration and management support.

Clients are referred in from a variety of sources, including by the delivering partners, NHS staff, social care, librarians and the Job Centre as well as via self referral.

They are given a project officer who assesses what support they need. That officer can be from any of the delivery partners and then coordinates the support with other partners. Most of the work is community based – clients are often met in cafes or community centres.

Current partners include Just Straight Talk, which offers workshops on employability skills such as team building and interview techniques as well as housing support, and the Beacon Centre which works with people with visual impairments.

Meanwhile, from the statutory sector there is the Dudley and Walsall Mental Health Partnership Trust and public health services that can provide lifestyle support to clients.

Steps to Work head of operations Stephanie Hammond said: "It is about tailoring the support around the individual. We might see them every week or just once a month and the support can last a few months to a few years. We have some clients who have been with us since the start. It really does depend on the individual's circumstances.

"These are people who have real barriers to finding employment. It can be financial, social or physical. Sometimes we work directly alongside social care or the NHS. The first step is to develop action plans and then to start organising support. We then go from there."

What has been achieved?

An evaluation of the programme in March 2019 by Enriched Consulting found the support given to people had had an extremely positive impact. A group of 31 clients were interviewed in depth. All said they were very satisfied with the help they had been given. They were also asked to rate the feelings out of 10 on a range of subjects at the start and end of the support.

The evaluation found:

- Sense of purpose increased from 1.8 to 8 on average
- Skills increased from 4.1 to 8.1 on average
- Confidence went up from 2.8 to 7.4 on average

The testimonies of individuals who have been helped also illustrate the positive effect of the programme.

Thomas Beale was homeless, had suffered a mental health breakdown and had poor health when he was referred to Bridges. His project officer helped find him accommodation and worked with him to build up his confidence. He is now being trained in welding and forklift driving. "I have had support before, but never with a such a caring approach. Nothing is too much. Thanks to the approach taken, I have started to realise my potential," he said.

Meanwhile, Andrew, who has autism and suffers from anxiety, spent time doing workshops to build confidence, communication and team-working skills. When he was ready, Bridges helped him produce a CV and apply for jobs. He is now working full time as an Amazon warehouse operative. He said: "Bridges has encouraged me to think about my future in a positive way."

"THESE ARE PEOPLE WHO HAVE REAL BARRIERS TO FINDING EMPLOYMENT. IT CAN BE FINANCIAL, SOCIAL OR PHYSICAL. SOMETIMES WE WORK DIRECTLY ALONGSIDE SOCIAL CARE OR THE NHS. THE FIRST STEP IS TO DEVELOP ACTION PLANS AND THEN TO START ORGANISING SUPPORT. WE THEN GO FROM THERE"

– STEPHANIE HAMMOND, STEPS TO WORK HEAD OF OPERATIONS

What lessons have been learned?

The programme was tasked with supporting 840 people with physical and mental health conditions by the end of June 2019. It more than achieved this – seeing over 1,600 in its first two-and-a-half years. It means just over half of its clients have a long-term condition. But this is very much a conservative estimate. The figures are taken from the initial assessments.

Ms Hammond said: "We have found that not everyone is willing to disclose their health condition straight away, especially if it is a mental health problem, or they may be unwilling to admit they have a health condition."

"So we have found we have had to be patient and help them access health support when they are ready for it. There is one woman we have been working with who only now is getting beginning to help for her mental health condition."

"We have partners – public health and mental health services – that we can link them to or we can help them attend a doctor's appointment. But until you start helping them address their health, you cannot make much progress with employment."

What is happening now?

The programme is constantly being refreshed with new delivery partners being brought in and some leaving. There are currently 19 on board.

Ms Hammond said: "We have found partners will leave. Some have been put off by the admin – there is quite a robust auditing arrangement because we have to prove our outcomes to our funders. So it does mean we do take on new partners because of that or because we see new opportunities for partners from different fields to get involved. It is evolving all the time."

"Recently we have had to re-organise our mental health support. We lost one partner so we have given Dudley and Walsall Mental Health Trust more of the funding to cover a wider population." And that evolution is set to continue. The programme only initially had funding until the end of 2019, but that has now been extended until 2022, allowing the programme to build on what it has achieved so far. It means total funding provided over the whole period – 2016 – 2022 – will be £17 million.



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South Somerset: creating an enhanced team around GPs

Summary

An integrated care model involving an acute hospital, GPs, adult social care, and the voluntary and community sector with activity driven by analysis of a linked dataset. For people with multiple conditions there are more than 40 health coaches and complex care teams that work from three hubs.



Main points

- South Somerset was part of NHS England's vanguard programme to test new ways of working
- Hospitals, social care, the CCG and 19 GP practices involved
- Complex care teams recruited to support individuals with complex health needs
- More than 40 health coaches appointed and embedded in GP practices to work with patients
- Hospital-based staff also started offering support via virtual clinics and community appointments

Context

Somerset is a county in south west England, covering a largely rural geography of 1,600 square miles. It is home to 550,000 people – a third of whom live in south Somerset.

Overall Somerset is generally healthy – life expectancy is above the national average – and has low rates of deprivation. But that masks the pockets of ill-health and deprivation that do exist and are increasing, particularly in rural areas.

Between 2010 and 2015 the number of local neighbourhoods falling into the most deprived fifth of areas rose from 14 to 25.



What was done?

In 2015 NHS England launched its vanguard programme to test new ways of working in the health service.

In Somerset a partnership between GPs, the council and local NHS put forward an application to become part of the pilot, leading to the creation of the Symphony Programme.

It covers the 19 practices in the South Somerset GP Federation, Yeovil District Hospital, Somerset Partnership NHS Foundation Trust and Somerset County Council.

The partnership is chaired by a GP and involves representatives from primary care, the local hospital, adult social care, the voluntary sector and Somerset CCG.

The vanguard was overseen through a programme board, chaired by a GP and including representatives from across health and care as well as the voluntary sector. In 2016 it led to the creation of a new organisation, Symphony Healthcare Services, to manage the new service.

The board worked with consultancy Iora Health, drawing lessons on changes made by other health systems across the world, and the University of York, which carried out an analysis on the health of the local population using hospital, primary care and social care data. It identified the presence of multiple conditions was a key driver of health service use rather than age.

The work led to the creation of a new integrated care model focusing on supporting people to understand and manage their own conditions and navigate health care, while linking together the system and patients.

One of the key steps was the introduction of health coaches – there are now more than 40 coaches in place, one for every 3,000 patients.

These are embedded in the GP practices and work with the GPs as well as the wider practice team. The coaches help patients to develop confidence to manage their conditions as well as ensuring that any liaison with other services is effective and coordinated.

Patients can contact the health coaches directly and will often see a coach or another member of the team instead of a GP, freeing up the GPs to focus on the most complex patients.

Meanwhile, the complex care team that had already been established was expanded. It went from a hospital-based team that worked with practices to being located in the community in three bases in South Petherton, Wincanton and Yeovil alongside community nursing teams.

The complex care teams work with patients, supporting them to better self-manage their conditions. They now have 12 full-time equivalent posts in total and include GPs, complex care nurses and key workers.

"THE BENEFITS HAVE NOT ONLY BEEN EXPERIENCED BY PATIENTS AND CARERS, BUT ALSO GPs LIKE MYSELF WHO ARE NOW MORE ABLE TO USE THEIR TIME TO CARE FOR THE MOST COMPLEX LONG-TERM HEALTHCARE NEEDS – HELPING TO MANAGE WORKLOADS"

- DR STEVE EDGAR, GP

Essential to the coordinate of care, are the regular 'huddles' at GP practices – sometimes happening daily – where the whole team discusses the patients they are most concerned about, agree what actions are needed and who will do what, whether the patient is at home or Hospital.

The complex care team join the huddle normally once a week and provide updates on patients they are already involved with and are allocated new patients where appropriate. This allows all the staff involved in the care of the most complex cases to share information, collaborate and spot problems early.

Yeovil Primary Care Network clinical director Kat Dalby-Welsh said it is the combination of all the measures that is the key to the success of Symphony.

"It is the sum of all parts. By looking at where we have had success we have been able to share this and replicate with similar patients or teams, which in turn grew our success"



“SYMPHONY HAS LED TO BETTER AND MORE JOINED UP CARE BEING DELIVERED TO PATIENTS AND WE EXPECT TO SEE THIS SUCCESS BE FURTHER BUILT ON IN THE FUTURE”

– JAMES RIMMER, CCG CHIEF EXECUTIVE

What has been achieved?

The work in south Somerset has been widely recognised. In 2018 the programme was named primary care team of the year in the British Medical Journal awards.

Over the last two years around 11,000 patients have received support from health coaches, while hospital admissions have been reduced by 7.5%, emergency bed days by 15% and non-elective admissions from nursing homes by 50% in 12 months.

Symphony chair Dr Steve Edgar said: “Teams across the partnership have worked incredibly hard together to design and develop new ways of supporting patients’ healthcare needs.

“The benefits have not only been experienced by patients and carers, but also GPs like myself who are now more able to use their time to care for the most complex long-term healthcare needs – helping to manage workloads.”

What challenges have been overcome?

Complex care clinical lead Dr Deb Gompertz said there have been a number of lessons learnt over the course of the past four years.

“Something like this takes time – and you certainly can’t do it on your own. The way teams have come together has been great to see. But we have also worked with other services. For example, the health coaches have worked together with the social prescribing network that we have in place across Somerset.”

This includes SPARK Somerset, which coordinates an online directory of local, low cost activities and services, and the community and village agents of Somerset Community Council, who are paid, part-time local residents who support vulnerable people in their communities.

“This has given patients access to a wealth of different groups and support services that have made a difference to their lives,” added Dr Gompertz.

But Dr Gompertz said one challenge they are still coming to grips with is related to IT. There are different systems used by social care, community NHS teams and GPs, although there are plans to create a platform so that all the system are compatible.

“That will make a big difference, but in the meantime we have had to communicate between teams to make sure records and information is shared between the different teams.”

What is happening now?

Alongside the health coaches and complex care team, other measures have been taken too.

This has included virtual diabetes clinics where a consultant from the hospital discusses the most complex diabetes cases with a practice team in a virtual format. This has enabled changes to be made to medication and management to better manage patients’ conditions, without the need for a hospital appointment.

Respiratory clinics have also been designed where practices can obtain an urgent opinion from a specialist nurse without attending an outpatient appointment.

The vanguard programme came to an end in 2018, but the success of the project convinced the CCG that local funding should be used to sustain the work. It has provided £1.7m of money to keep it running until 2021.

CCG chief executive James Rimmer said the work done by Symphony has been both “innovative and collaborative.”

“Symphony has led to better and more joined up care being delivered to patents and we expect to see this success to be further built on in the future.”

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Learning from other research

Many others have and are conducting research into the problems and solutions of multiple conditions. Consistent findings and recommendations emerge along with a range of helpful tools and resources.

Bristol University's [3D study](#) was the largest ever randomised control trial of a patient-centred intervention to improve care for people with multiple conditions. The trial, which involved over 1,500 people, was designed to test the effectiveness of a patient-centred approach that focuses on quality of life and promotes self-management. The study showed that making health reviews more person-centred results in people experiencing a higher quality of care.

The [National Institute for Health and Care Excellence \(NICE\) published guidelines](#) on the clinical assessment and management of multiple conditions for healthcare professionals, people living with multiple conditions and their carers. The aim of the guidelines is to improve quality of life by promoting shared decisions based on what is important to each person in terms of treatments, health priorities, lifestyle and goals. Individualised care plans based on a person's goals are recommended along with medication and treatment reviews.

The University of East Anglia [GoalPlan](#) research team, funded by the National Institute of Health Research (NIHR), conducted a feasibility study into an approach to help GPs and people with multiple conditions identify personal goals and priorities. Working with six practices in Norfolk it found the approach was well received by GPs and people with multiple conditions. An online learning package is now being developed so that other GPs can easily learn about a method to agree personal goals and use them to prioritise people's care.

The Sharing Evidence Routine for a Person-Centred Plan for Action ([SHERPA](#)) framework is a project funded by the National Institute for Health and Care Excellence and Keele University. Previous research identified that communication skills training for GPs did not work as well as it could for people with multiple conditions. SHERPA aims to give GP trainees a structured approach to manage consultations with people who have multiple conditions. Teaching materials are currently in creation.

A [2018-19 RCGP Spotlight survey of multimorbidity management in primary care](#) found that time and workload pressures limit GPs ability to adapt to the changing needs of people with multiple conditions. If this was relieved, then professionals see continuity of care as most important for people with multiple conditions. While large variations in existing practice for people with multiple conditions were found, guidance for using motivational interviewing techniques when exploring common aspects of care for people with multiple conditions has been developed. The development of templates to support more coordinated approaches for multiple conditions is also being explored.

The [Movement for All programme](#) is a partnership between the Richmond Group of Charities and Sport England as well as Activity Alliance, Mind and Parkinson's UK. This collaborative programme seeks to support people with long term and multiple health conditions to be active by understanding and addressing the barriers to activity through a behaviour change approach. The programme has different elements. First specific physical activity interventions and insight projects with a focus on multiple conditions are managed by individual charities. Second a common evaluation framework aims to synthesise learning across different projects to ascertain what works, what is transferable, replicable and scalable. Third is the delivery of a mass media marketing campaign "We Are Undefeatable" that aims to re-frame the way we talk about physical activity and encourage people with long term conditions to move more by focussing on inclusivity, clear identification and realistic inspiration.

The results of research with people severely affected by mental illness is set out in the [Rethink Mental Illness report 'Building Communities that Care'](#). The report sets out evidence of how increased access to psychological therapies has had a significant impact on people that live with low to moderate mental health issues. For people severely affected by mental illness more community support to address issues related to things like housing, employment and debt advice would be welcomed, and access to independent advocacy. It makes a case for different sectors, organisations and people living with multiple conditions to work together in partnership in local areas to deliver this type of wrap around support.

The [COINCIDE trial](#), involved 36 GP practices in the North West of England, to test the effectiveness of an integrated collaborative care model for people with depression and long term physical conditions. It found low intensity psychological therapy delivered in partnership with practice nurses in primary care can reduce depression and improve self management of chronic disease in people with mental and physical multimorbidity.

The [University of York CHEMIST study](#) is testing the feasibility of the community pharmacy as a setting to deliver psychosocial intervention for people with multiple conditions suffering from low mood or depression. Community pharmacy staff are trained to deliver an Enhanced Support Intervention (ESI) designed to reduce depressive symptoms and prevent progression to major depression over 4-6 sessions. A smaller pilot study found that community pharmacies are an appropriate setting to deliver preventative psychological support to people with multiple conditions at risk of depression. Learning from the pilot study was incorporated into the ESI training materials for this Randomised Controlled Trial.

[A study by the University of Liverpool, on the 'Social determinants of multimorbidity and multiple functional limitations among the ageing population of England 2002-2015'](#) was published in June 2019. Researchers found that the likelihood of multimorbidity and multiple functional limitations was consistently associated with the levels of household wealth, sense of control over one's life, physical activity and loneliness.

Guy's and St Thomas' Charity has recently published research, with Demos, on [how to reduce financial difficulty among people at risk of developing multiple conditions](#) in Lambeth and Southwark. The results highlight evidence that poor health can make it hard for people to work, which leads to reduce income. Low income can then lead to further ill health. Proposals to break this cycle by improving financial health include taking a more innovative approach when supporting people to manage fluctuating incomes, and to stagger their money, welfare and debt advice.

Another Guy's and St Thomas' Charity project, with Rocket Science, looks at [practical interventions that can support people with multiple conditions to engage with meaningful work](#). This research found that people who are better supported to self-manage their condition, and feel empowered to do so, are more motivated to access employment.

Other research that is currently underway includes [Versus Arthritis](#) studies on pain, and care and support planning, and the [Alzheimer's Society](#) studies on dementia and diabetes, and dementia and cancer. Research on multiple conditions is increasingly being given profile and brought together by the collaborative work of the Medical Research Council, the Academy of Medical Sciences and the NIHR through a [shared platform on multiple conditions](#), as well as specific research funding. The NIHR and Keele University supported [INCLUDE study](#) – Integrating and improving care for patients with inflammatory rheumatological disorders in the community – is currently evaluating the feasibility and acceptability of a nurse-led integrated care review for people with inflammatory rheumatological conditions in primary care.

Research methodology

In this review we set out to find out what practical approaches are already in place for working with people with multiple conditions. The approach was not an extensive literature and case study review, but a targeted approach to better understand examples of practice that was already in place and what could be learnt from it.

We held 18 semi-structured interviews with people across health and care, the charity sector, in policy roles, think tanks and professional bodies. The names and organisations of interviewees are provided below. There was a group discussion with the Richmond Group Policy and Influencing Directors in June 2019 and regular project team discussions with the Taskforce partners.

We put out an official call for case studies across the Taskforce's networks in May 2019. We also conducted targeted desk research of previous case study reviews, relevant funds and associations, and other sources that were identified through the interview process.

Many recommendations of promising practice came from the interviews and desk research. These were combined with responses from a public call out for case studies published in early summer 2019. In total 45 case studies were reviewed and ten are analysed in more depth in the guidebook.

Interviewees

Diana Billingham, Gloucester County Council
David Buck, King's Fund
Will Chapman, Gloucestershire Clinical Commissioning Group
Carolyn Chew-Graham, GP and Keele University
Becky Haines, GP and Royal College of General Practitioners
Nick Goodwin, Integrated Care Foundation
Ross Gribbin, Imperial Health Partners
Ulrike Harrower, Public Health England South West
Ruth ten Hove, Chartered Society of Physiotherapy
Nevilla Kallfa, Public Health England South West
Moira McGrath, NHS Lambeth CCG and London Borough of Lambeth
David Oliver, Royal College of Physicians
Lindsay Oliver, Year of Care
Liam O'Toole, Versus Arthritis
Raj Patel, NHS England
Don Redding, National Voices
Andrew Seaton, Gloucestershire Hospitals NHS Foundation Trust
Jon Siddall, Guy's and St Thomas Charity

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The Multiple Conditions Guidebook was published by the Taskforce on Multiple Conditions in November 2019. This guidebook is part of a suite of resources that can be used in different ways and for different purposes. These include a summary slide deck, shareable graphics, an infographic and standalone summaries of key text and the case studies.

The guidebook and other resources will be available to download on:

www.richmondgroupofcharities.org.uk/taskforce-multiple-conditions

The Taskforce would like to encourage people to use these resources in whatever way suits their purposes. This includes on websites, media (social or otherwise) in presentations, research documents, or other publications.

You do not need to ask permission but please do acknowledge the source: Taskforce on Multiple Conditions (2019) 'The Multiple Conditions Guidebook'.

The aim of this work is to share learning and practical tools for designing and delivering approaches that work for people with multiple conditions. But this is not a one-way process. Please also share your learning and practical experiences with each other and us.



The Multiple Conditions Guidebook

*A REPORT FROM THE TASKFORCE
ON MULTIPLE CONDITIONS*

November 2019

www.richmondgroupofcharities.org.uk/taskforce-multiple-conditions

The
Richmond
Group
of Charities



Royal College of
General Practitioners