Adults with multiple long-term conditions in Brighton & Hove

Executive summary
November 2018

Part of the Joint Strategic Needs Assessment programme

NHS
Brighton and Hove
Clinical Commissioning Group

Brighton & Hove City Council

The needs assessment

The number of people living with multiple long-term conditions is considered to be on the rise, in part because more people are living longer than ever before with accumulated health risks, but also due to unhealthy lifestyles and other factors. Multiple long-term conditions have been shown to be more predictive of hospital use than single specific conditions or age. People who have both mental and physical health conditions do worse than those who just have physical health problems and the likelihood of having a mental health condition increases as the number of physical conditions increase.

This needs assessment is conducted as part of the programme of Joint Strategic Needs Assessments overseen by Brighton & Hove Health & Wellbeing Board. The overall aim is to assess the health and wellbeing of adults with, and at risk of developing, multiple long-term conditions (MLTCs) in Brighton & Hove and to make recommendations for future commissioning and provision of integrated health and care services. Objectives are:

- To assess the size, impact and characteristics of the population with MLTCs - adults who have two or more long-term physical or mental health conditions
- To conduct an evidence review for prevention of developing MLTCs and for care, treatment and support for patients with MLTCs
- To assess how different parts of the local system respond to patients with MLTCs and their carers (this was done through interviews with professionals and online surveys with adults with MLTCs, their carers and professionals, local information from the National GP patient survey and information on local services)
- To make recommendations for the prevention of developing MLTCs and the care, treatment and support for patients with MLTCs and their carers.

Within this summary we provide a high-level overview of adults with multiple long-term conditions in the city, along with detailed recommendations under each of the following six calls to action:

1. Scale up primary, secondary & tertiary prevention across life course

2. Integrate mental and physical health

3. Focus on adults with multiple long-term conditions

4. Target specific conditions, settings and deprived areas

5. Improve integration and care coordination

6. Improve data and information sharing and systems

Our findings chime with those from the November 2018 Health Foundation report *Understanding the health care needs of people with multiple health conditions,* which states that the NHS needs to have a clear focus on people with multiple conditions. The Health Foundation report suggests six key steps to improve care for this group which are similar to our calls for action: supporting those with multiple conditions to live well; developing new models of NHS care for those with multiple conditions; resourcing the vital role of primary care; designing secondary care around those with multiple conditions; using data and sharing information to improve care for those with multiple conditions; and evaluating what works.

For further information please contact kate.gilchrist@brighton-hove.gov.uk or Nicola.rosenberg@brighton-hove.gov.uk

Adults with multiple long-term conditions in Brighton & Hove

There are over 51,000 adults aged 20 years or over in Brighton & Hove recorded as having multiple long-term conditions (two or more) as at March 2017 (22% of adults) (Table 1) and **around 8,000 with five or more conditions.**

These figures are similar to estimates published by Public Health England, based upon a large scale study in Scotland and applied to our population (21% of people with multiple long-term conditions). We have significantly higher estimated prevalence than the South East for all age groups under 85 years, but because our population is younger our overall estimate is lower than the South East and England (both 23%).

Table 1: Prevalence of long-term health conditions in adults aged 20+, Brighton & Hove, March 2017

	Prevalence of health conditions	Number of adults (aged 20+)
No health conditions	54%	126,826
1 condition	24%	55,211
2 or more conditions	22%	51,379
5 or more conditions	3%	8,084
Physical and mental health co-morbidity	8%	19,060
All registered patients (20+)		233,416

The percentage of people living with long-term conditions increases with age (Figure 1). In 20-24 year olds 74% have no long-term conditions and up to the age of 50 years the majority of people in Brighton & Hove still have no long-term conditions. At 50-54 years, 22% have multiple long-term conditions, rising to 48% of those aged 65-69 years and 81% of those aged 85-89 years. However, those who reach 95 years or over have fewer conditions than those aged 80-94 years. This picture was similar for both males and females.

Figure 1: Percentage of people with specified number of long-term conditions, by age group, Brighton & Hove, March 2017
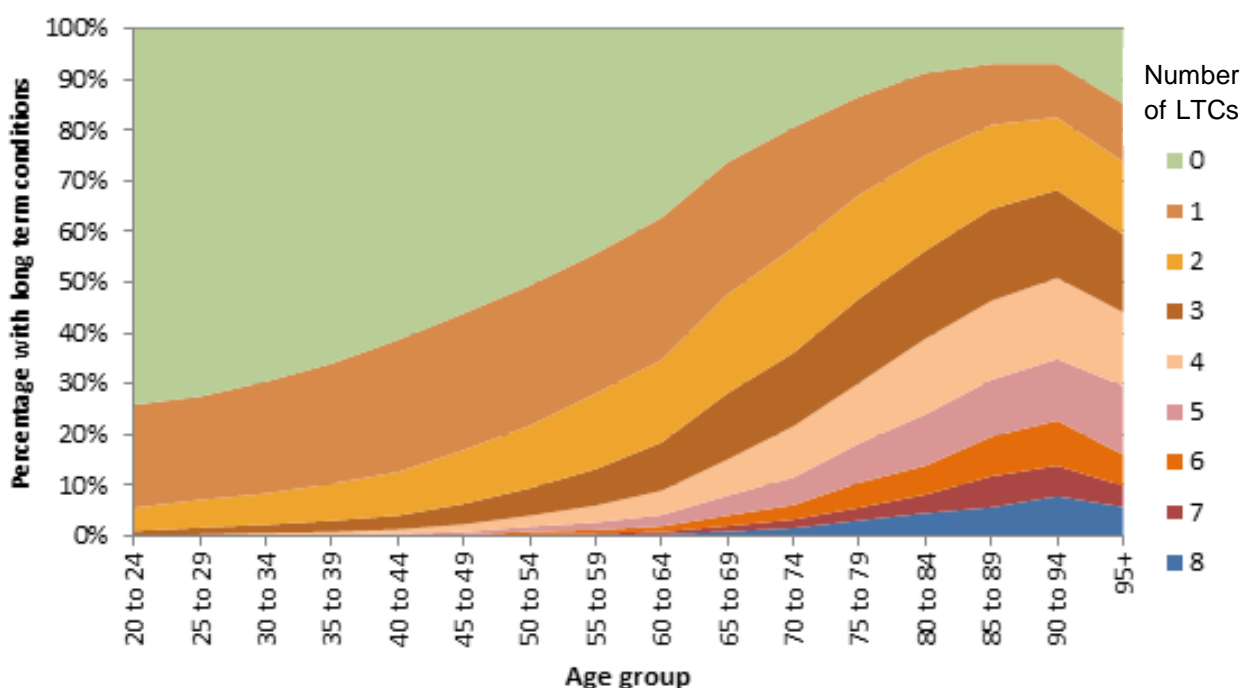
The average number of hospital inpatient admissions, A&E attendances, outpatient appointments, prescribed medications and GP practice contacts are highly related to the number of long-term conditions an individual has (Table 2).

Table 2: Average number of hospital admissions and attendances, GP practice contacts[1] and prescribed medications in the past year by number of long-term conditions

	Average outpatient appointments	Average emergency inpatient admissions	Average elective inpatient admissions	Average A&E attendances	Average GP practice contacts[1]	Average distinct prescribed medication count
<2 conditions	0.9	0.0	0.1	0.2	2.3	2.0
2+ long-term conditions	3.7	0.2	0.4	0.6	11.1	10.0
5+long-term conditions	6.6	0.7	0.7	1.3	19.2	18.2

The combinations of conditions adults with multiple long-term conditions have tend to vary by whether male or female in those aged under 65 years. In those aged 65 years or over, the same set of conditions appear to be most common whether male or female. We looked at how conditions cluster together, most clusters were age-related or due to common pathophysiological pathways (for example an association between obesity and diabetes), but **in younger adults there was a large cluster of adults with mental health and substance misuse (drugs or alcohol) issues.**

1. Scale up primary, secondary and tertiary prevention across the life course

Without upscaling prevention, the numbers of people with multiple long-term conditions in the city could increase by over 10,500 people to over 62,000 by 2030, **with almost 2,900 more emergency admissions to hospital and £16.7million more in acute healthcare costs per year**, based upon expected population growth and an increase in prevalence of 5%, similar to that within a national study.

If the prevalence of MLTCs increases by 5% by 2030:

There would be 62,003 adults with MLTCs (up from the current 51,379 adults in 2017) (10,624 more adults)

An increase in emergency admissions to an estimated 14,724 admissions a year (up from the current 11,850 total emergency admissions in 2017) (2,874 more admissions)

A resulting increase in acute healthcare costs (emergency, elective, outpatients and A&E) to an estimated cost of £84.6million a year (up from the current £67.9 million a year in 2017) (an increase of £16.7million)

---

[1] Note: GP contacts do not equate to appointments. They are an overestimate as include administrative changes to records, however are likely to reflect higher GP practice activity for patients with MLTCs)

We would need to see a decrease in prevalence of over 13% for there to be any reduction in the number of people with multiple long-term conditions in the city by 2030, because of our growing population.

Obesity, substance misuse and being a current or ex-smoker are all highly significant risk factors for having multiple long-term conditions. Of those adults who are recorded as obese, 56% have multiple long-term conditions compared with only 10% of adults who are not obese. Of those with recorded alcohol or substance misuse issues 43% have multiple conditions compared with 10% of those with no record of this. Of current or ex-smokers, 31% have multiple conditions compared with 17% of those who have never smoked.

In the interviews and surveys professionals and people with MLTCs say greater focus on prevention, including activities to keep people well, is needed. As well as increased resource and support for empowering people to self-manage their conditions. In the online survey, 40% of people with MLTCs say support for self-management is a challenge and professionals called for more time and resources, so that it was possible to look at needs holistically and help prevent the escalation of conditions.

Of those with MLTCs responding to the NHS England GP patient survey for Brighton & Hove, 21% felt socially isolated within the last year compared with 7% of those with 0-1 condition. Evidence from the voluntary and community sector highlighted prevention of social isolation and loneliness for key groups.

Recommendations for scaling up prevention

1. **Develop a one stop prevention referral pathway, including social prescribing,** for all health and social care services with services supported to actively refer. Social prescribing supports people to improve their health and wellbeing by connecting them to non-clinical community services. This needs to be considered in commissioning.
2. More capacity and training for staff to support **self-care and self-management** in primary, secondary, tertiary and social care. Self-management programmes and efforts must be tailored to the individual's culture and beliefs and clinical needs, and underpinned by a collaborative and communicative relationship with professionals. Care must be taken for self-management approaches to be appropriate and not over burdensome.
3. Social care to work more with those not meeting care thresholds to **support wellbeing.**
4. Multi-sector focus on addressing **social isolation and mental health and wellbeing,** including referrals to ageing well and other community and voluntary sector services to prevent social isolation by health and social care services.
5. Primary care to be supported to **identify people with, or at risk of, MLTCs**, opportunistically through routine care and proactively using electronic health records.
6. **Workplace wellbeing initiatives**, starting within the organisations providing care.
7. **Integrate primary prevention,** namely smoking prevention and stop smoking services, physical activity, weight management, substance misuse and alcohol across services. This can be through Making Every Contact Count to encourage all those who have contact with people to talk about their health and wellbeing and provide active signposting.
8. **Strengthen secondary and tertiary prevention,** in particular screening, early diagnosis, falls, cardiac, stroke and other rehabilitation
9. Adopt a more **person-centred approach**, tailoring support as appropriate and in a targeted way to adults with MLTCs.
10. **Continue to address polypharmacy and inappropriate prescribing** through proactive medication reviews and use of primary care records.

2. Integrate mental and physical health

Just over 19,000 adults in the city have both mental and physical health long-term conditions (8%). This increases to 35,000 (15%) if mild depression is included. The likelihood of having a mental health condition increases as the number of physical health conditions increases and is much greater in people living in more deprived areas.

The majority (63%) of adults with multiple long-term conditions under 65 have a recorded mental health condition and / or recorded substance misuse (alcohol or drugs misuse). However, in adults aged 65 or over, the majority (77%) do not.

In the surveys of professionals and adults with MLTCs, **links between mental & physical health services is the greatest challenge**. Respondents highlight increased needs of people with physical and mental health issues and that more joined up care is needed for those with mental illness for their physical conditions. Common themes from the professionals' interviews include:

- The complexity of services, care coordination, boundaries between care challenging
- A lack of a healthcare system for MLTCs
- A requirement for there to be more of a focus on mental health
- Training / education being needed to bridge the divide and focus more on mental health.

Recommendations for integrating mental and physical health

11. Increase and **strengthen training for the health and care workforce** in all sectors on mental health, to ensure that in all services mental health is prioritised alongside physical health. This is to specifically increase signposting and referrals to mental health (primary mental health care including increasing access to psychological therapies), wellbeing and healthy lifestyle services.

12. Inclusion of psychological / mental health initiatives **within disease management or rehabilitation programmes**. This is shown to be cost effective and results in reduced service use. Increase involvement of primary mental health and wellbeing services across health services.

13. Strengthen support across health and care services for addressing depression to enable people **to better self-manage conditions**. CBT-based interventions improve treatment adherence, psychosocial adjustment and coping skills. People with co-morbid mental health problems can gain most from self-management support programmes.

14. Health and social care services to be supported to strengthen work with the **community and voluntary sector** as they work at the intersection between individuals' mental, physical and social needs and provide support groups and peer-delivered plus other services preventing further exacerbations.

15. Develop a **check list for commissioning** of health and care services to ensure integration of mental and physical health.

16. Develop a more joined up approach to commissioning mental health / illness services **to avoid gaps in services** between primary and secondary mental health care.

3. Focus on adults with multiple long-term conditions

Hospital activity costs (in particular emergency admissions) increase exponentially as the number of long-term conditions an individual has increases (Figure 2). Whilst only 22% of adults have multiple long-term conditions, they account for 82% of all emergency admission costs in Brighton & Hove in the year prior to March 2017.

Figure 2: Average cost per person of various acute care in the last year, by number of conditions; Brighton & Hove, March 2017
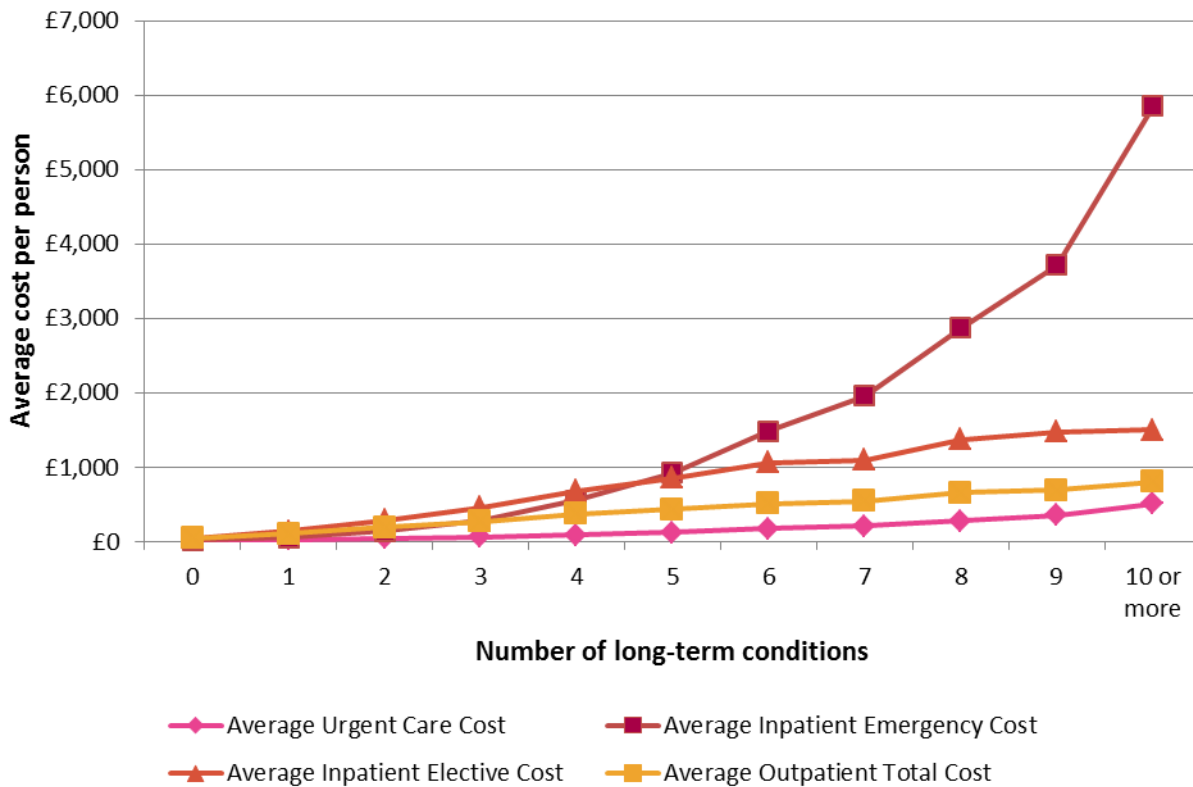
In adults aged under 65, those with fewer (2-3) long-term conditions living in the most deprived quintile had the highest total costs in the past year. In adults aged 65 or over, those with greater numbers (5-6) of conditions had the highest total costs, with little difference by deprivation quintile.

Around three-quarters (73%) of prescribing costs were attributable to those with multiple long-term conditions (22% of adults), with 27% attributable to those with five or more conditions (3% of adults).

Among adults aged 65+ in the city, 11% are classed as moderately or severely frail (9% moderately frail and 2% severely frail), according to the electronic frailty index (eFI). Emergency hospital costs, in particular, in adults aged 65+ are driven by multiple long-term conditions: adults with moderate / severe frailty explain up to a third of costs, but focusing only on this group will have less impact than on focusing on those with multiple conditions as 95% of emergency admission costs could be attributed to the 62% of adults aged 65+ with multiple conditions.

Adults who are moderately or severely frail, but have lower numbers of long-term conditions (0.6% of adults) have emergency admissions costs of £0.5million in the last year. However, those who are **not** moderately or severely frail but have five or more long-term conditions (2.3% of adults) have emergency admissions costs of £8million per year (Table 3). It is this group which requires more intensive support and proactive management.

Table 3: Emergency admission costs in the past year by frailty and number of long-term conditions summary table, Brighton & Hove, March 2017

Frailty	Number of long-term conditions				
	0	1	2-4	5-7	8+
Fit / null (includes all adults under 65 years)	Very large numbers of people (96%, 223,935 people) with fewer conditions and less frail. Total emergency admissions costs of £15.3m			2.3% (5,254) who are not frail but who have 5+ LTCs. Require intensive support and proactive management. Total emergency admission costs of £8.0m	
Mild					
Moderate	Small number (0.6%, 1,397 people) of people who have fewer conditions but a high degree of frailty. Total emergency admissions costs of £0.5m			1.2% (2,830 people) who have 5+ LTCs and frail who require intensive support. Total emergency admission costs of £5.3m	
Severe					

If you only focus on older adults with moderate or severe frailty, you miss out on 62% of patients who are most at risk of high total costs or an emergency admission in the next year and 87% of those patients you do intervene with are not people who are most at risk of high costs or emergency admission.

The professionals interviewed said that it was difficult to have an impact with severely frail adults and thought it was better to target those who are less severely frail. They highlighted a gap in the care of younger patients with multiple long-term conditions and that there is currently no plan for how to respond to this. Evidence and data shows that targeting of the top 1% of frail people for intervention isn't cost effective and that Brighton & Hove has a significant population with multiple long-term conditions aged under 65 years.

Recommendations for focusing on adults with MLTCs

17. GP practices to be supported to **proactively identify those with MLTCs** who are not yet frail to prevent decline. A gap exists in the identification of the non-frail; however they too may be elderly, complex and often hospitalised. Proactive identification is also relevant for younger patients, particularly with mental health and substance misuse issues.
18. Frailty co-existing with MLTCs implies a significant level of vulnerability and therefore **proactive frailty services** in the community are needed.
19. **Support adults with MLTCs** to access support for prevention. For health and social care to be supported to prevent functional decline and frailty, maintaining a person's mobility. This can be through increased access to physiotherapy, other forms of appropriate exercise plus social interaction.
20. Many carers live with MLTCs, identifying **carers** is essential to increase access to support through the Carers Hub. Health professionals are in a unique position to validate carer's roles and encourage support seeking.

4.Target specific conditions, settings and deprived areas

The highest percentages of people with multiple long-term conditions (age-standardised) are concentrated around the more deprived Moulsecoomb and Bevendean and East Brighton wards and areas of North Portslade and Woodingdean.

Prevalence of multiple long-term conditions is greater in the most deprived areas of the city compared to the least deprived and this is most noticeable between the ages of 40-64 years, where prevalence is doubled.

Prevalence of five or more long-term conditions has an even more marked difference. **With people having 5+ conditions around 15 years earlier in the most deprived areas of the city** (Figure 3).

Figure 3: Proportion of adults with 5+ LTCs by age group in the most and least deprived quintiles, Brighton and Hove, March 2017
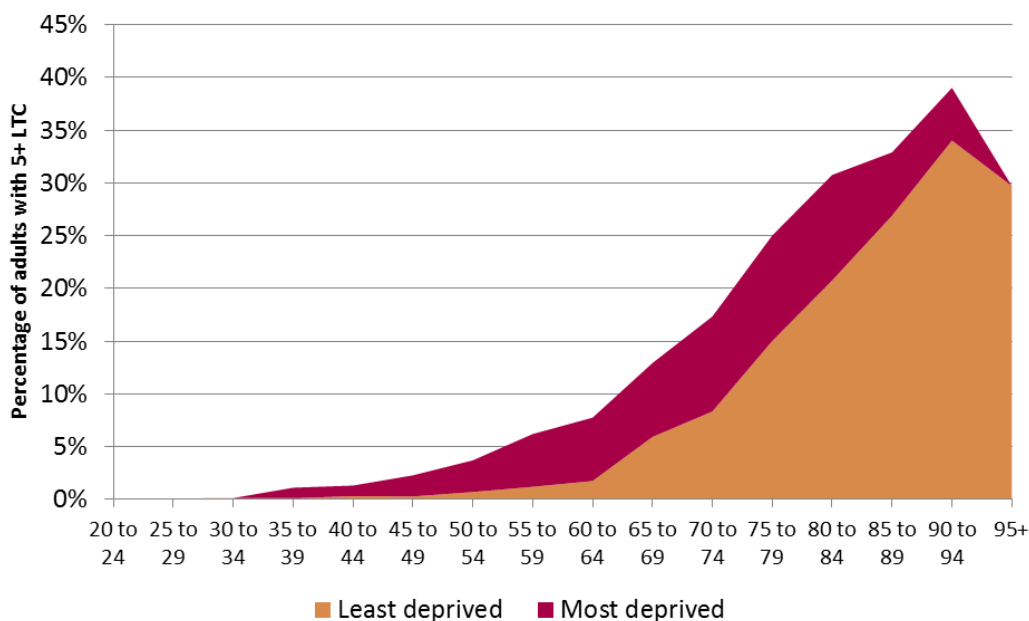
In terms of numbers, there are more adults with multiple long-term conditions in Brighton & Hove aged under 65 years (27,923) than there are aged 65 years or over (23,456). There are also more females (27,239) with multiple conditions than males (24,140).

In the interviews, professionals said that GPs have no easy to use, systematic way of identifying and flagging people at risk of, or with, MLTCs, although there are ways of identifying patients for medication reviews. Targeting of adults of MLTCs, as well as specific priority conditions and in key settings (as highlighted below), is needed.

Dementia is a very commonly specified condition for adults with multiple long-term conditions in receipt of social care, it is increasing in prevalence and there is a shortage of residential / nursing provision in the city for dementia. In 2017/18, 43% of delayed transfers of care related to people awaiting dementia placements. In the interviews, professionals identify those living with dementia as particularly vulnerable due to the complexity of care required.

From the professionals' interviews, there is a **lack of access to palliative / end of life care for people with MLTCs, as services tend to focus on people with cancer.** Interviews highlight opportunities to improve palliative / end of life care within nursing homes and for people with heart failure to be seen earlier by the palliative care teams. An example of good practice is provision of welfare / benefits advice to carers of those in the palliative care pathway.

Professionals, in the interviews, also highlighted the **needs of housebound patients, with more outreach and support required**. They report that services should work better together, with better coordination of multiple professionals visiting in a week and for there to be more preventative services made available including transport and with better outreach into people's homes and communities as well as into residential and nursing homes.

Care homes and nursing homes gaps in care result in increased pressure on the health and care system. Patients within care homes are often multimorbid with complex needs yet are poorly served by secondary care. Coupled with the increasing pressures on homes from dementia, end of life care and MLTCs, this setting is considered to be a priority for focus.

Similarly, a **lack of appropriate bariatric care** was highlighted, in relation to provision and mechanisms for supporting (e.g. beds and wheelchairs) those who are obese.

For **adults with learning disabilities** the multi-morbidity burden is greater, they have higher morbidity, earlier mortality and more unidentified health needs than the general population.

Recommendations for targeting specific conditions, settings & deprived areas

21. **Proportionate universalism** to be applied as part health and social care commissioning and in contracts with providers –so that universal services are provided but with greater resource within the most deprived areas to address increased prevalence of adults with MLTCs in those under 65.
22. GP practices to be supported to conduct **holistic annual reviews** and to facilitate better coordination across specialities.
23. Health and social care services to **enable trusted assessments** and **staff to share tasks** as appropriate, reducing duplication of effort and increasing support as required.
24. **Review access to community care and primary care services**, including transport, to ensure that care takes place in the most appropriate setting, to strengthen secondary prevention and reduce exacerbations.
25. **Early diagnosis of dementia** within primary care, and care and support for people living with **dementia** to focus more on improving quality of life, independence and patient and carer priorities as well as prevention of exacerbations of MLTCs.
26. **Ensure access to palliative / end of life care** for people with MLTCs without cancer. Provision of palliative care beds within care homes is needed to enable those with MLTCs to receive better end of life care in the community.
27. Primary, community care and nursing homes to carry out **better Advanced Care planning** as a means of extending personal autonomy in the event of lost capacity.
28. Commissioners to review provision of **bariatric care**, in relation to health and care provision and mechanisms (e.g. beds and wheelchairs) for supporting those who are obese.
29. Review and develop **nursing home nursing workforce** provision and training.
30. Review the **role of geriatricians** in residential and nursing homes and community services.
31. Review capacity of primary care to **support adults with learning disabilities.**

5. Improve integration and care coordination

Without integrated data systems, we have been unable to look at people's pathways through health and social care within this needs assessment. However, the majority of Adult Social Care clients with multiple long-term conditions (66%) are in receipt of physical support for personal care (frailty) and 14% have memory and cognition as their primary support reason (usually dementia).

There has been an increase in new long-term care placements for younger adults (aged 18-64), with the biggest increases seen in mental health and physical support placements. Social work services are reporting increasing complexity and acuity of cases. This is borne out by an increase in the proportion of nursing care placements as opposed to residential care placements; in 2015, 39% of older clients were in nursing care compared to 46% in 2018.

In both the professionals and individuals' surveys, 41% of respondents and 47% of carers, say **referrals between health services are a challenge,** 42% of professionals say **referrals between health and social care are a challenge**. Both surveys demonstrate how better integration and care coordination is needed to improve outcomes. Highlighting:

- Mental health affects a person's ability to communicate
- Good communication with people with MLTCs and between services is essential
- Primary Care care plans are not holistic enough and other organisations' care plans are not being shared systematically
- There is a lack of capacity in primary care to communicate clearly, or understand the behaviour of, vulnerable people such as those with learning disabilities
- Longer appointments are needed to allow time to address multiple / complex needs, for people to open up, or for those who have difficulty attending multiple short appointments (e.g. those with mobility issues)
- Long-term condition annual reviews, including mental health reviews, could be combined
- Health services set up to manage individual conditions, social care how people manage; the links between services are unclear to professionals, those with MLTCs or their carers
- Working in siloes, short-term, target-focused care is the norm; there is need of, and value in, a holistic approach that includes peoples' goals and values.

The interviews highlight significant challenges in **care coordination & multidisciplinary working**:

- Social workers felt other professionals weren't clear about their roles and they found health services difficult to navigate
- Secondary care is good at one condition in a multi-disciplinary way, but not good at managing people with MLTCs, with lots of clinicians involved, in a combined way. There is no forum for this, mainly email referrals or phone calls happening in a disjointed way
- The need for the co-location of health and social care professionals
- Development of a trusted assessor model so that professionals can share roles and responsibilities and avoid duplication of effort
- Primary care professionals feel social care is distant, under resourced, with high thresholds
- Developing relationships between primary care and community nurses; there is a lot of duplication in activity
- The need for access to specialist advice, including geriatricians
- More inclusion of the community & voluntary sector to support those with MLTCs & carers
- The value of shadowing of other services
- Development of more responsive and supportive services in general.

Recommendations for integration and better care coordination

32. Senior leaders of all health and care commissioning and provider organisations to commit to giving permission to staff to focus on multi-sector relationships with the specific aim of improving health and wellbeing outcomes for adults with MLTCs. Aspirational intent to work together is needed; **integration is not transactional, it is about relationships and trust.**
33. **A strong, appropriately skilled, multi-disciplinary team** is one of the most effective ways to deliver holistic, long-term care to those with MLTCs. Commissioners and providers to look

11

at ways of working together better across health and social care for all their conditions and the development of multidisciplinary **guidelines** for MLTCs.

34. Health and care providers to add **electronic decision support systems** within information systems to improve care for people with MLTCs.

35. **Continuity of care with GP practices is important, as well as quality interactions with professionals. Resource is required for longer appointments** with appropriate clinicians in primary care for those living with complexity or with five or more long-term conditions.

36. Community care services and GP practices to have better **access to specialist advice** from secondary care and mental health providers.

37. **Holistic personalised care planning** to be carried out by trusted, appropriate community care or social care professionals and embedded within GP practice systems. This improves people's capacity to manage their conditions and effects are greater when care planning is comprehensive, intensive and integrated into routine care.

38. **Improve care coordination,** particularly for older adults, which significantly improves outcomes. Successful care coordination has a holistic focus which supports people and carers. Commissioners to invest resources in **the role of the care coordinator**. Providers to ensure that professional support is provided to ensure the role is effective.

39. **Reduce unplanned hospital readmissions** through structured discharge planning and communication. This includes a system for secondary care to proactively identify and for primary and community care to review patients at high risk of readmission. For there to be a reconciled list of medicines on the GP record following discharge.

40. **Review and develop a directory of local health and care services** to better connect different parts of the system.

6. Improve data and information sharing and systems

This needs assessment would not have been possible without linked data from primary and secondary care. This data isn't now available and so it is not possible to look at pathways of care, or to monitor the prevalence and impact of multiple long-term conditions. **All professionals interviewed mentioned information sharing,** particularly difficulty in getting relevant information from other health professionals and not having shared IT systems that every health and social care professional can access relevant information. This is also a key challenge identified by those with MLTCs (17% say it works well) and carers (50% think it is a challenge).

Recommendations for better data systems and information sharing

41. Commissioners and providers to review **sharing of information** between health and social care professionals and to facilitate information sharing to improve individuals' care, appointments, care planning, coordination, prevention and self-management and ensure health and care professionals have access to relevant information in a timely manner.

42. **Invest in commissioning and provider data systems** across health and social care to **enable linkage of non-identifiable data and information to improve evidence based commissioning of services and to be able to evaluate programmes.**

43. **Invest in integrated data systems** across health and social care **to identify people with multiple long-term conditions** and prioritise them for proactive care.

44. **Better use of and recording of data** across health and social care (e.g. capturing appointments on GP practice systems). Training for professionals is required to improve data completeness and quality.

45. For data to be collected on **people's experiences** in order to augment routinely collected health and care data and for this to be provided alongside routine health and care data.