Multimorbidities

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Multimorbidity

Introduction

Multimorbidity in its broadest sense has been defined as the combination of one chronic disease with at least one other disease (acute or chronic) or biopsychosocial (biological, psychological or social) factor (associated or not) or somatic (related to or affected by the body) risk factor. It is often defined more simply as the coexistence of two or more long term conditions. Generalist and multiagency care is particularly relevant to people with multimorbidity, while specialist care is usually organised around care for a single condition (NICE 2016).

Who is at Risk and Why?

Multimorbidity increases markedly with age, but it is also found in younger people, especially in socially deprived areas where the co-existence of physical and mental health problems is particularly common. Multimorbidity is associated with poor quality of life, disability, psychological problems and increased mortality. Multimorbidity is also associated with increased frequency of health service use including emergency hospital admission, adverse drug events, polypharmacy, duplicate testing and poor care co-ordination. Polypharmacy is often significantly driven by the introduction of multiple drugs intended to prevent future morbidity and mortality, but the case for using such drugs weakens as life expectancy reduces. The absolute difference made by each additional drug may also reduce when people are taking multiple preventative medicines (NICE 2016).

The Level of Need in the Population

There is wide evidence that the number of long-term conditions has greater influence on a patient’s use of health services than specific diseases, which highlights the importance of studying chronic illness as opposed to acute illness. There is widespread recognition that chronic illness multimorbidity and its rising prevalence is a concern for health service provision and health workforce planning. However, research in this area is not very extensive, and few studies have been carried out in England (Diarra 2015).

The following charts have been derived from the Kent Integrated Dataset (KID) which is a whole population local person level linked dataset involving more than 250 organisations. GP data has been used to quantify the extent of the multimorbidity in the Kent population. Note that the KID is under constant development and updating so not all Kent practices are reflected in this analysis which took place in July 2016.

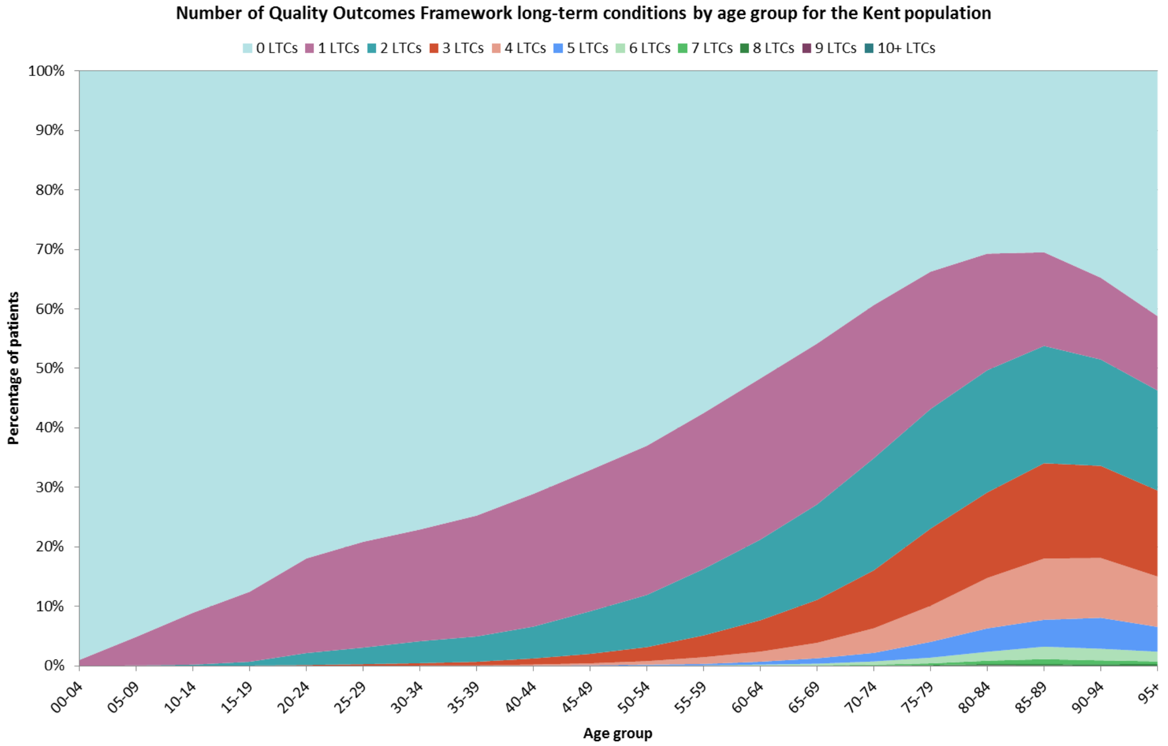
Figure 1 shows the prevalence and distribution of multimorbidity (using different colour codes) by five year age bands, based on long-term conditions (LTCs), as defined by Quality and Outcomes Framework (QOF). For the population aged 75 and above, 67.4% had one or more QOF LTC, with 28.3% having three or more QOF LTCs. A similar pattern is seen in

Figure 2 when distribution of multimorbidity for all LTCs is defined in the KID. Note the 'survival effect' seen as the prevalence of multimorbidity starts to reduce after the age of 90 years.

Figures 3 and 4 show the distribution of multimorbidity by named QOF LTC and all LTCs respectively. It is clearly seen that existence of co-morbidities with important LTCs like diabetes, asthma and dementia is the norm not the exception. This has implications as to how services should be planned more robustly, taking into account the realistic impact of clinical guidelines which are predominantly focused on patients with single LTCs not multiple morbidities.

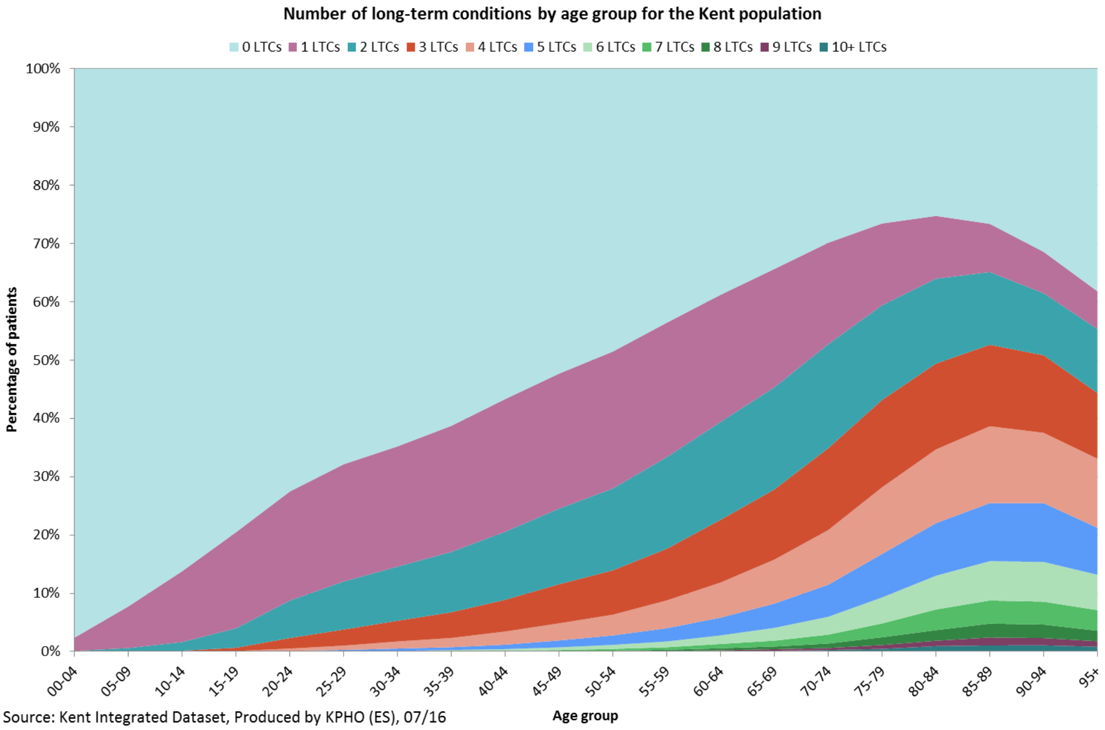
Figures 5 and 6 show the crude differences between average health and social care costs of patients for multimorbid patients and whole population by age. The differences are quite significant between multi-morbid patients with QOF LTCs versus whole population with very high costs in younger age groups. These variations need to be explored in detail. Across the whole population, the older population require greater health and social care resources. The population with two or more QOF LTCs however, use more resources across all age bands, although this gap narrows from the age of 60 and above.

Figure 1:



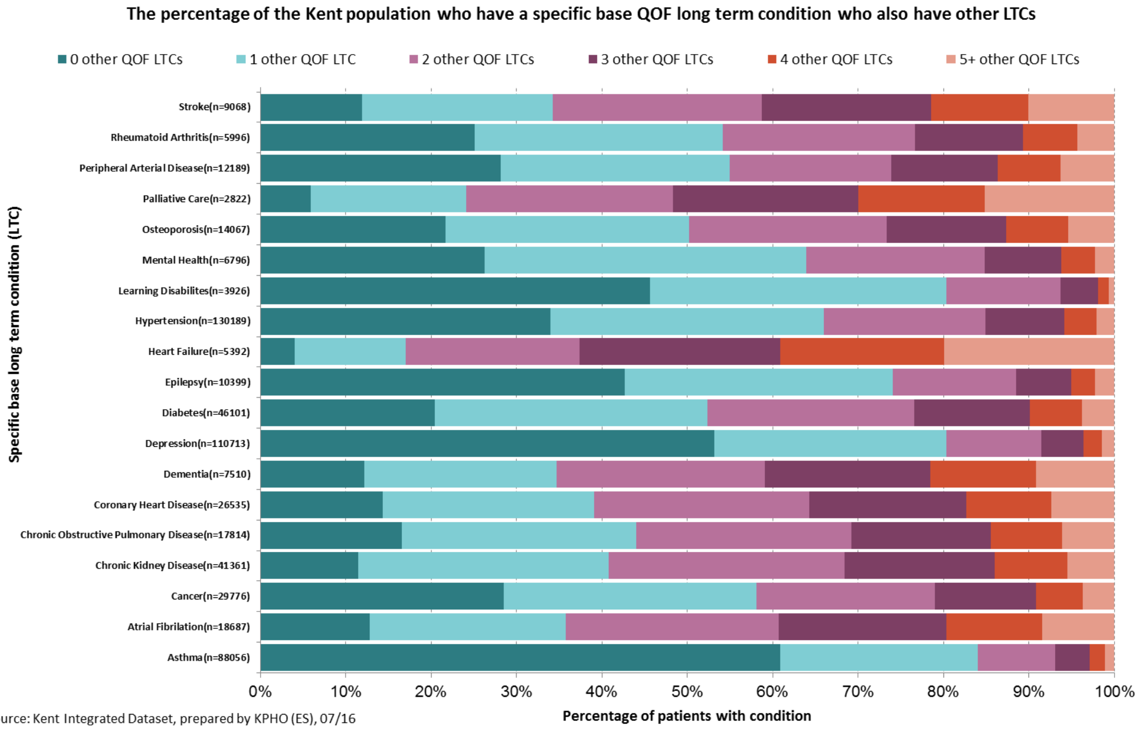
Source: Kent Integrated Dataset, Produced by KPHO (ES), 07/16

Figure 2:



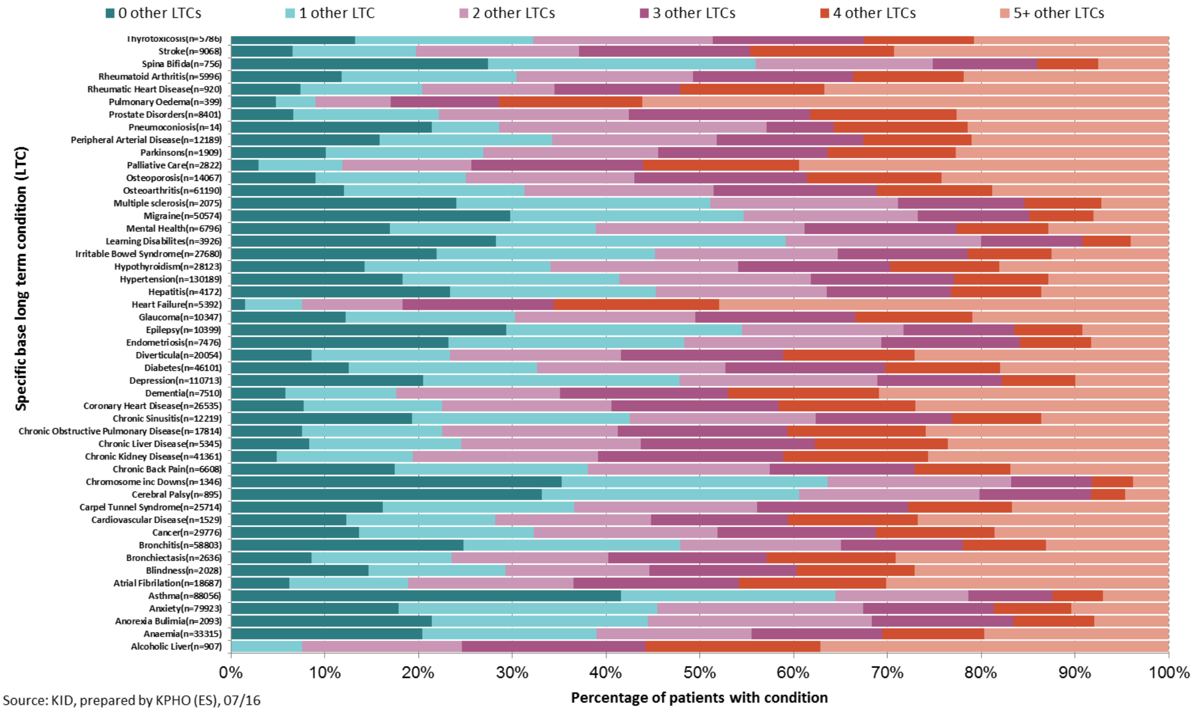
Source: Kent Integrated Dataset, Produced by KPHO (ES), 07/16

Figure 3



Source: Kent Integrated Dataset, prepared by KPHO (ES), 07/16

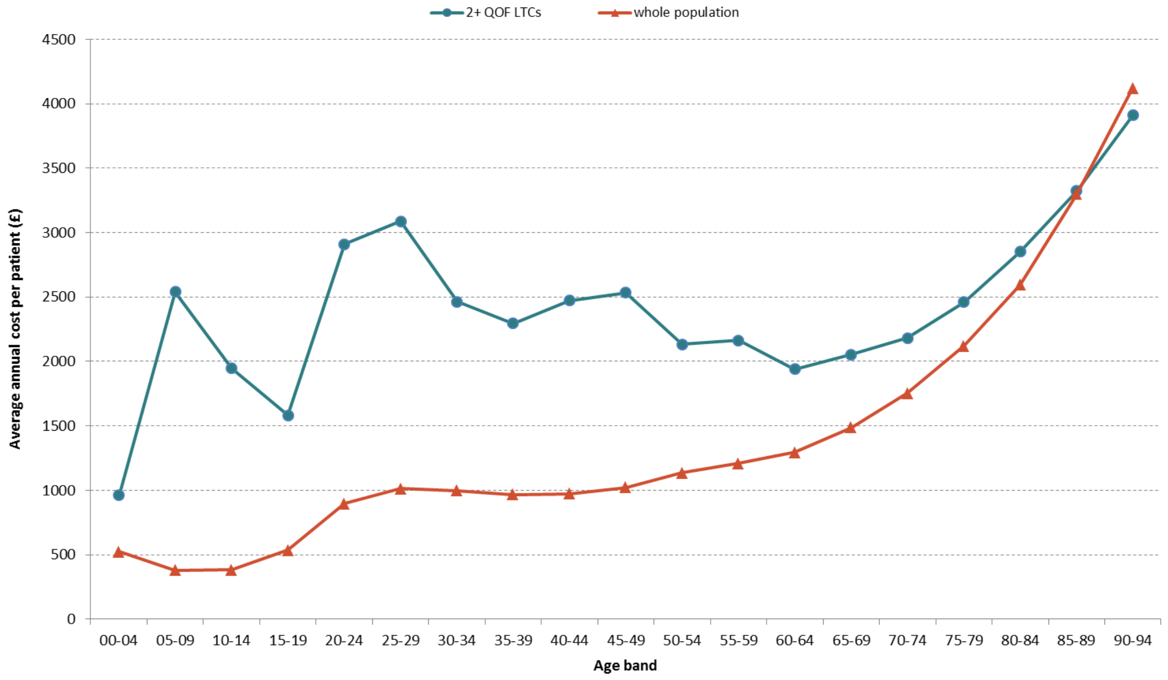
Figure 4



The percentage of the Kent population who have a specific base long term condition who also have other LTCs

Source: KID, prepared by KPHO (ES), 07/16

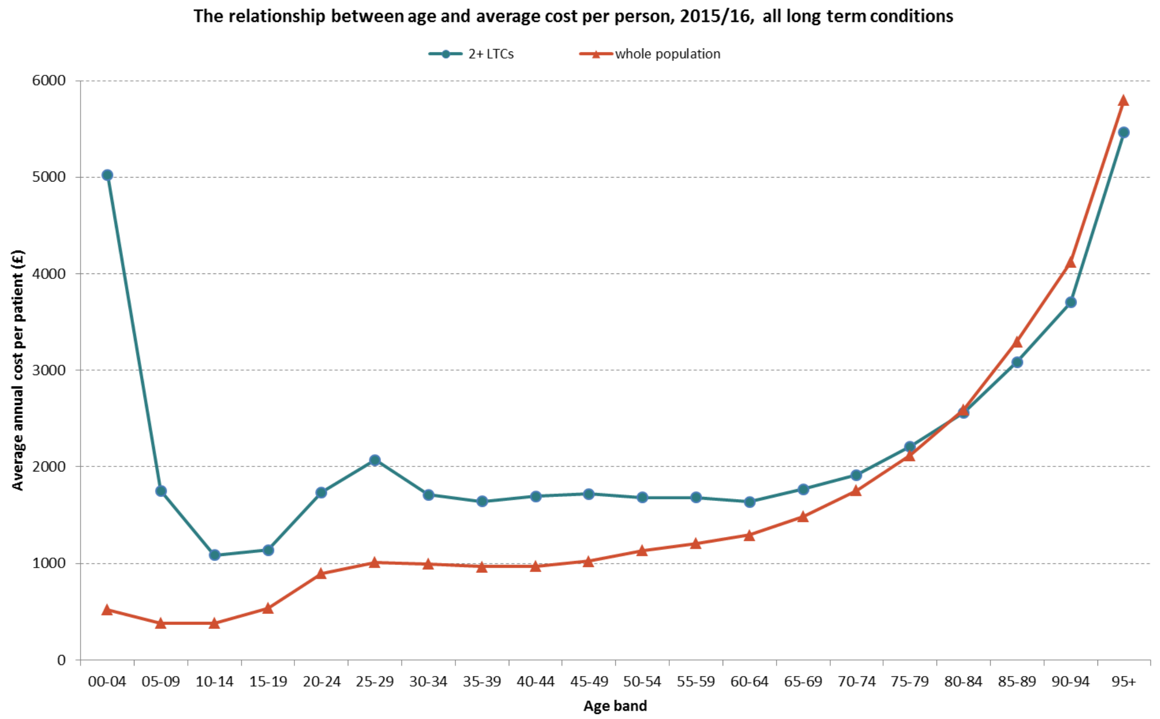
Figure 5



The relationship between age and average cost per person, 2015/16, QOF long term conditions

Source: Kent Integrated Dataset, prepared by KPHO (ES), 08/16

Figure 6



Source: Kent Integrated Dataset, prepared by KPHO (ES), 08/16

Current Services in Relation to Need

Progress has been made both locally and nationally to emphasise the importance of integrated care for people with multiple LTCs. The management of care for people with LTCs should be proactive, holistic, preventive and patient-centred, building on the House of Care model as outlined by the King's Fund (2013). The model critically focuses on collaborative personalised care planning with the patient which is a continuous iterative process. The model also emphasises the link between care planning both at a patient, as well as commissioning for local populations, level - including use of local authority services (social care and public health) and community resources, alongside more traditional health services.

Projected Service Use and Outcomes in Three to Five Years

There are currently no national frameworks or regional attempts to robustly model the differential increases of comorbidities at a whole population level.

User Views

The patient's experience of their own healthcare is an important aspect of care quality that has been shown to improve clinical and other outcomes. Individuals with multimorbidity report better experiences of care when they are knowledged and involved in the decision-making, when their care is well coordinated and communication is good. A greater focus on disease prevention, stronger collaboration between health and social care services, and the provision of more integrated care for people with mental and physical health problems would also help to improve the patient experience.

Advocacy groups can amplify the patient voice and improve access to care, as well as provide information and support to patients and their families. Patients have an important role in preventing multimorbidity and improving its management and should be involved in the development of health policies and the delivery of healthcare services. Inequalities in access to quality healthcare must also be addressed.

Patients with multiple LTCs more frequently report worse experiences in primary care. However, patient-centred measures of health-related quality of life, especially pain, are more important than the number of conditions in explaining why patients with multiple LTCs report worse experiences of care (Paddison et al 2015).

Participants endorsed the need for longer consultations, relational continuity and a holistic approach. All felt that training and support of the health care staff was important. Most participants welcomed the idea of additional self-management support, though some practitioners were dubious about whether patients would use it. The pilot study led to changes including a revised care plan, the inclusion of mindfulness-based stress reduction techniques in the support of practitioners and patients, and the stream-lining of the written self-management support material for patients.

Unmet Needs and Service Gaps

The Kent and Medway Sustainable Transformation Plan (STP) (2016) states that our population is expected to grow by 90,000 people (5%) over the next five years. Twenty thousand of these people will be in the new town in Ebbsfleet. Growth in the number of over 65s is over four times greater than those under 65. An aging population means an increasing demand for health and social care. Over 500,000 local people live with long-term health conditions, many of which are preventable and many of these people have multiple LTCs, dementia or mental ill health.

Recommendations for commissioners

NHS England (2016) have summarised a list of key recommendations:

- Commission appropriate person-centred services that promote and embed personalised care and support planning. This includes developing service specifications and innovative payment and contracting methods which promote partnership and collaboration in local health populations.
- Consider which patients would benefit most from personalised care and support planning using risk stratification tools or identifying people with lower levels of health literacy or confidence.

- Commission a range of support for self-management services to supplement traditional services and to ensure a more than medicine approach e.g. structured education programmes, peer support networks, coaching.
- Promote the development of the workforce to have the skills and competencies to work in this way, ensuring space for ongoing training, development and reflection, both for commissioners and providers.
- Ensure a robust local measurement system is in place to inform and support improvement.

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