# HEALTH AND WELLBEING BOARD PAPER

# FORMAL PUBLIC MEETING

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| **Report of:** | Greg Fell |
| **Date:** | 13th December 2018 |
| **Subject:** | Multi-morbidity |
| **Author of Report:** | Eleanor Rutter |

**Summary:**

This paper provides a background summary of the challenge of multiple morbidity and introduces a Board conversation on how Sheffield should meet that challenge.

**Questions for the Health and Wellbeing Board:**

- Is the board committed to delivering a 'Sheffield Healthy Lifespan': the number of healthy life years Sheffield residents should expect to live, and ensuring that it is fairly distributed across the city?
- Is the board committed to a whole life-course, whole city approach, to ensure that Sheffield is a great place to grow older? What are the board's asks and expectations of its members, partners and stakeholders (including the long term conditions work stream of the ACP)?
- Is the board committed to a meaningful shift in the budget from hospital to community-based interventions, ensuring the money is allocated according to need, to deliver the long term ambition of a radical programme to delay and prevent multi-morbidity, as well as ameliorating its effects? What does the board believe its role is in making this happen?
- Does the board support the principle that care services should be integrated and wrapped around individuals and families and that people should be encouraged to

be experts in their own health? What is the board's role in ensuring that systems will be designed on that basis?

- Does the board agree that what matters most to a person, should be the basis of all decisions and support the development of person-centred approaches to care across the entirety of the spectrum of need? What will the board do commit to ensuring that staff have the required skills to focus on quality (not just quantity) of life?

**Recommendations for the Health and Wellbeing Board:**

**N/A**

**Background Papers:**

N/A

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**What outcome(s) of the Joint Health and Wellbeing Strategy does this align with?**

Improved outcomes due to the prevention or delay of multi-morbidity could be seen as the culmination of all the ambitions related to starting and developing and living and working well.

**Who have you collaborated with in the writing of this paper?**

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# Multi-morbidity

## 1.0 Introduction

1.1 Multi-morbidity describes a situation where an individual is living with two or more long term conditions. The number of long term conditions increases across the life course and can, in simple terms be viewed as the precursor to frailty: as the number of medical conditions increases, quality of life decreases and difficulties with everyday activities increases, with a concomitant increase in need for support from informal carers or statutory services. The higher the number of conditions and the greater the severity of those conditions, the greater the functional decline.

1.2 It is a common misconception that 'the ageing population' is responsible for inexorable increases in demand for health and social care services. This is not the case. Many older people, including very elderly people, live fully independent lives - the increase in demand for services far outweighs the increase in older people and is, in fact, due to increasing numbers of people living with one or more long term condition.

1.3 GP records show that almost 40% of the population in Sheffield has at least one long term condition and 94,110 have two or more – there are almost as many people in Sheffield living with multi-morbidity as there are with a single long term condition. The most common conditions that are seen in multi-morbid people are hypertension, depression and diabetes.

1.4 Whilst the prevalence of long term conditions tends to increase with age, this does not mean that age per se is responsible. Indeed multi-morbidity is more common in the 60-69 years age group than in those aged 80-89 years.

1.5 Multi-morbidity has a devastating impact on health and wellbeing outcomes for individuals, is in danger of overwhelming the health and social care system and has a detrimental economic impact on the city when people of working age are rendered unable to work.

## 2.0 Multi-morbidity

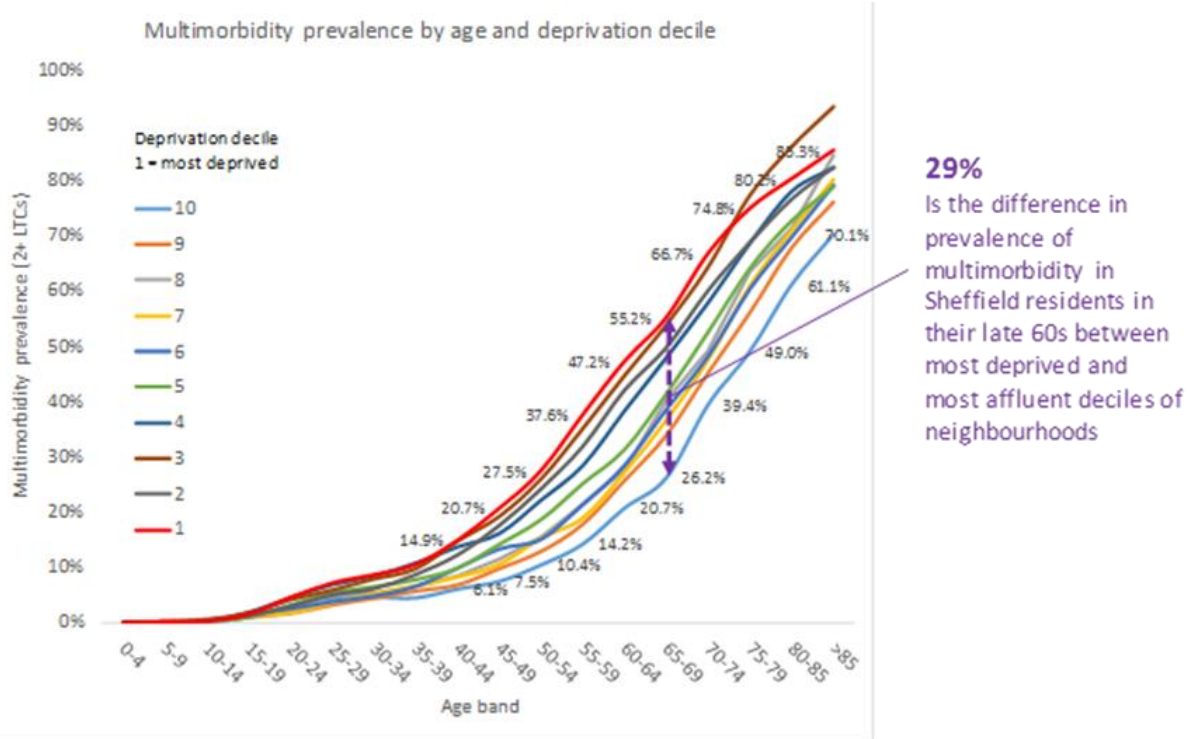
### 2.1 Inequalities in health

In Sheffield, people living in the most deprived areas or who have limited choice over where they live, for example, due to low income, lack of available work or disability, are more likely to find themselves in circumstances that have a harmful impact on their health and wellbeing. This puts them at greater risk of developing multiple long term conditions at a much earlier age than people who are more affluent – by the age of 60, 1 in every 2 people who are in the most deprived 10% of people in Sheffield have multiple long term conditions, compared to only 1 in 5 people in the most affluent 10% (figure 1). People living in deprived areas are also more likely to experience a mental health illness as part of their multi-morbidity than their counterparts in more affluent

communities. So if we really want to address the large inequality in age of onset of ill health (and multiple illnesses), then we need to focus on:

- the best start in life
- healthy schools and pupils
- helping people find good jobs and stay in work
- active and safe travel
- warmer and safer homes
- access to green and open spaces and the role of leisure services
- strong communities, wellbeing and resilience
- public protection and regulatory services (including takeaway/fast food, air pollution, and fire safety)
- health and spatial planning

**Figure 1: Multi-morbidity prevalence by age and deprivation decile, Sheffield**




## 2.2 Mental wellbeing

Depression is the second most common condition found in people with multi-morbidity, present in 40% of people. Not only is depression more likely in individuals with a physical long term condition, but the presence of depression makes taking

steps to maintain good physical health even harder. It thus represents a vicious cycle of worsening outcomes.

## 2.3 Prevention

### 2.3.1 A city that supports wellness

If we really want to prevent people from developing multiple long term conditions, then we need to address the wider determinants of health – 'the causes of the causes'. As a system we need to look to achieve health and wellbeing through the actions we take that shape the city we live in – such as our strategies for housing, education, the economy, transport, the local environment, and how we put communities at the heart of decision-making.

### 2.3.2 Resilient communities

People's own strengths and networks, connected to the assets and resources in their local communities and the wider city, are the key to wellbeing and improving quality of life. We need to work together as organisations and with our communities to build places and deliver services that support and sustain these. This means changing how we work with people and communities in Sheffield to enable them to have greater control of what matters to them. Improving people's quality of life will benefit everyone in the city and will also help public services be sustainable over the long term.

### 2.3.3 Person-centred approaches

A highly specialised, disease-specific approach is not appropriate for people with multi-morbidity as focusing on disease markers for one illness can have a detrimental effect on another and pharmacological interventions can interact with each other producing unpredictable and difficult to manage side-effects that can end up being worse than the symptoms of the disease/s. Thus a generalist and person centred approach must be taken to understand what is most important to any given person and how they may be enabled to care for their own health and live a meaningful life within the confines of their illness.

### 2.3.4 Primary care

Local intelligence shows that a one year delay in onset and development of complexity could save £4m per year in hospital costs alone. This could be achieved in part by shifting the focus of monitoring the known diseases of people on GP registers, to using that as an opportunity to prevent second and subsequent long term conditions.

## 3.0 **Questions for the board**

### 3.1 **Vision**

Is the board committed to delivering a ‘Sheffield Healthy Lifespan’: the number of healthy life years Sheffield residents should expect to live, and ensuring that it is fairly distributed across the city?

### 3.2 **Health supporting city**

Is the board committed to a whole life-course, whole city approach, to ensure that Sheffield is a great place to grow older? What are the board’s asks and expectations of its members, partners and stakeholders (including the long term conditions work stream of the ACP)?

### 3.3 **Resilient communities**

Is the board committed to a meaningful shift in the budget from hospital to community-based interventions, ensuring the money is allocated according to need, to deliver the long term ambition of a radical programme to delay and prevent multi-morbidity, as well as ameliorating its effects? What does the board believe its role is in making this happen?

### 3.4 **Integrated services and self-care**

Does the board support the principle that care services should be integrated and wrapped around individuals and families and that people should be encouraged to be experts in their own health? What is the board’s role in ensuring that systems will be designed on that basis?

### 3.5 **Person centred care (including social prescribing)**

Does the board agree that what matters most to a person, should be the basis of all decisions and support the development of person-centred approaches to care across the entirety of the spectrum of need? What will the board do commit to ensuring that staff have the required skills to focus on quality (not just quantity) of life?