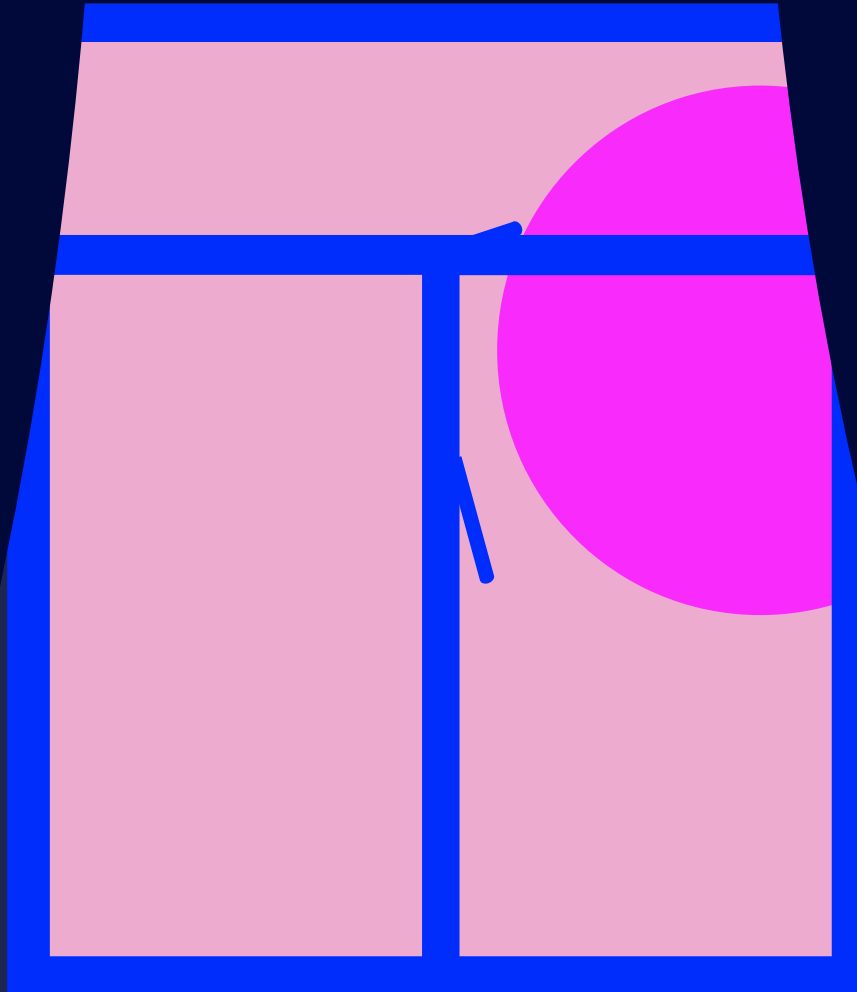


Taskforce on Multiple Conditions

Case study updates



The Multiple Conditions Guidebook - One Year On

December 2020

The
Richmond
Group
of Charities



Royal College of
General Practitioners

The Taskforce on Multiple Conditions is a partnership between The Richmond Group of Charities and Guy's and St Thomas' Charity, supported by 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>

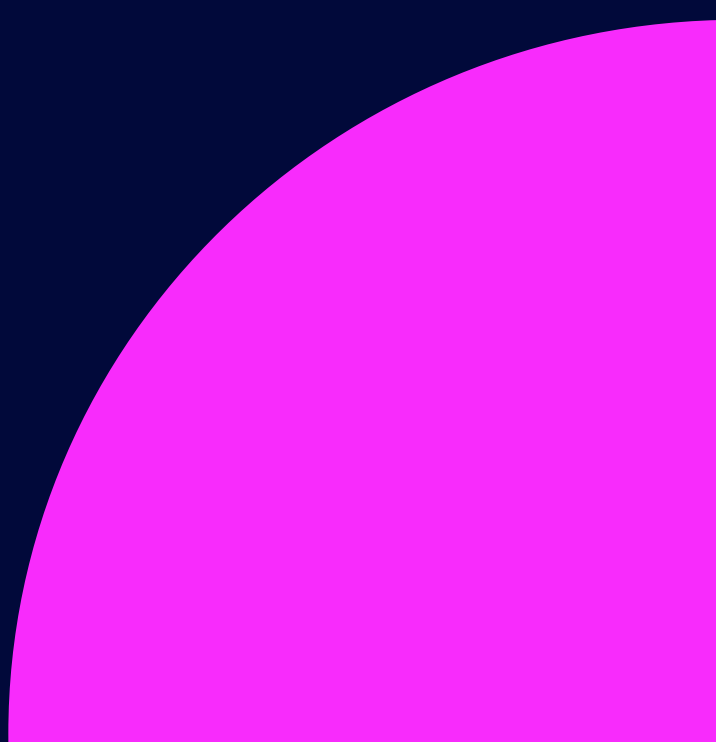
Acknowledgements and thanks

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Introduction

The [Multiple Conditions Guidebook](#) was published by the [Taskforce on Multiple Conditions](#) in November 2019. It profiled 10 practical approaches that work with and for people living with multiple health conditions. In summer 2020 the Taskforce released a short [animation](#) highlighting this study of good practice.

In Autumn 2020 the Taskforce revisited a number of the original Guidebook case studies to find out what happened in the year since their original publication. Clearly COVID-19 means 2020 has been the kind of year that no-one was expecting. Conversations detailing the impact on people with multiple conditions, and the practitioners and services supporting them, are set out in this report with case study updates from the Black Country, British Lung Foundation, Cornwall, Gateshead, Luton, Southwark and Yorkshire.

With the pandemic still ongoing and all the complexities it involves, now is not the time to draw concrete learning from a small number of case studies. As such this report does not attempt to make policy recommendations, instead it focuses on highlighting what we heard from practitioners and people with multiple conditions. The case studies outline the ways that people overcame new challenges and explores where there are ongoing issues to address. They also highlight new possibilities for improving the lives of people living with multiple conditions. The intersection between inequality and multiple conditions, to date underrepresented in discussions but made more visible by the pandemic, is highlighted in all the case study updates. A number of other themes, that are consistent with much other research from this time, are set out as summary findings.

Given the mission of the Taskforce we hope that these findings and the case studies will be of use to the health and care sector – including local NHS bodies, councils and charities, as well as national policy makers and other organisations working in this field. This work has relevance now as we navigate winter and the ongoing pandemic, but also for the longer term as we aim to maximise opportunities for new ways of thinking and working in the future that have arisen from having to do things differently during this time.

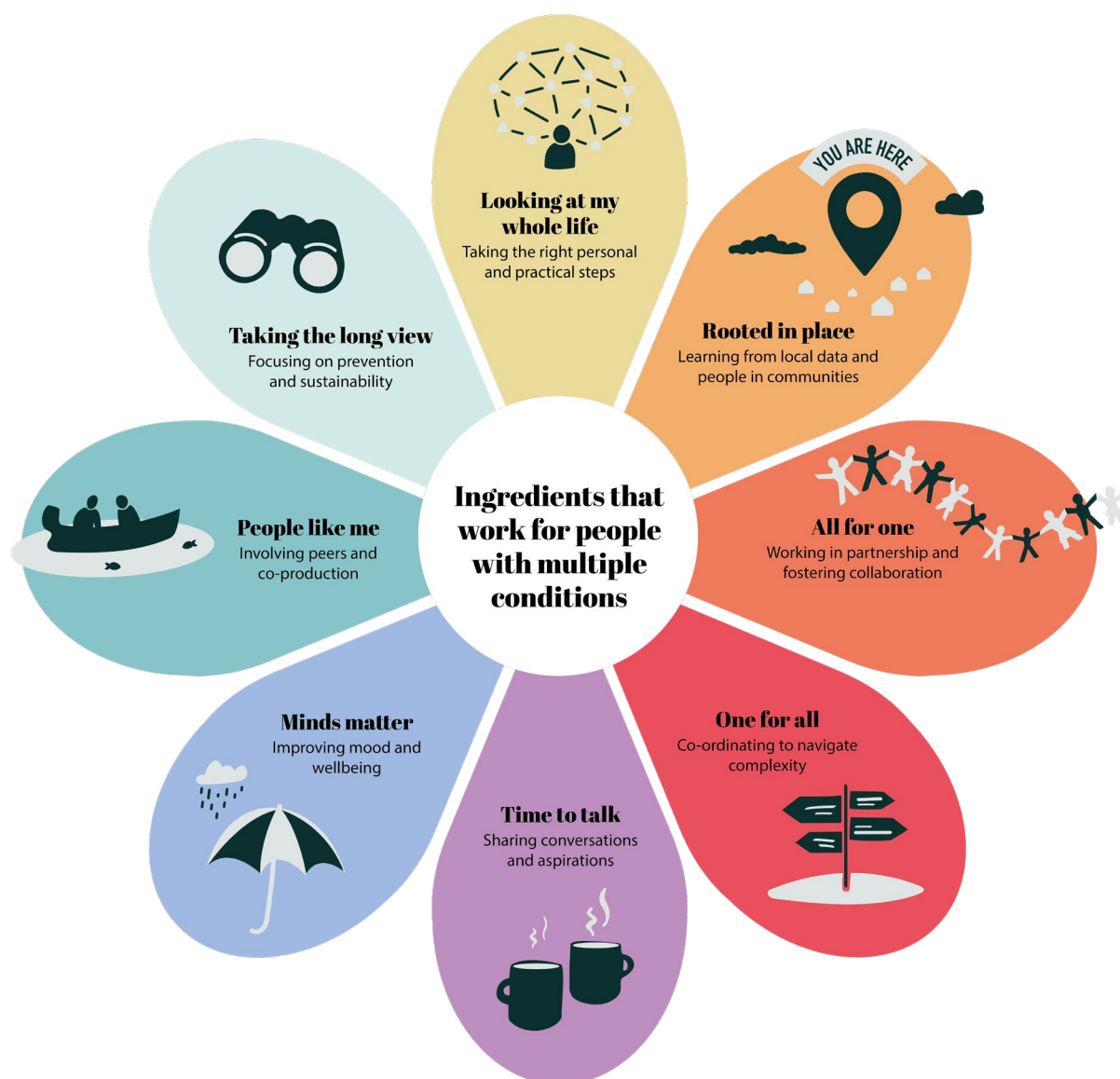
Even during a global pandemic like COVID-19 we find there are multiple solutions and responses for people living with multiple conditions. We are sharing a small number of case studies from our work but we encourage others to share their own examples and learning with us and each other.



Background

In the original Guidebook some of the examples of good practice for people with multiple conditions involved doctors, nurses and other healthcare professionals. But many were not medical and instead included things like people with multiple conditions running support groups, specialist exercise trainers helping people to find ways to keep physically active and a charity-led partnership supporting people to reduce their barriers to employment.

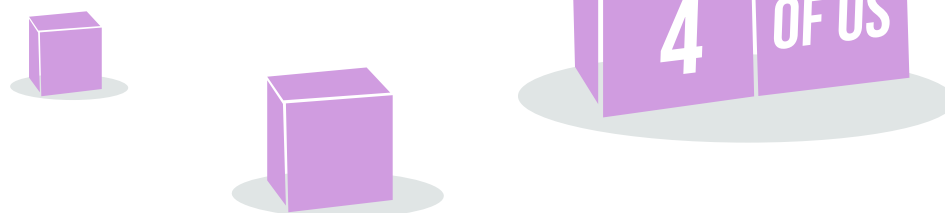
Whilst all the practical examples studied were different, we identified eight common ingredients. By sharing these ingredients along with the practical learning in the form of case studies, the Taskforce hoped to give people on the frontline – whether in the NHS, a local council, a charity or in the community – some insights and tools for how their own practice can improve the lives of people living with multiple conditions.



The Guidebook aimed to build a shared understanding of ways to tackle the challenge of multiple conditions. This is a significant issue, affecting millions of people across England, and the burden is not shared equally. Multiple conditions affect people in deprived areas 10-15 years earlier than elsewhere and Black, Asian and minority ethnic (BAME) communities are disproportionately impacted.

Key points

In England around one in four of us have two or more long-term health conditions and this number is growing.



From a policy point of view, reducing the impact of multiple conditions is not straightforward or a quick fix. There are multiple layers of complexity arising from how our individual, social, environmental and economic circumstances influence our health, as well as links between different physical and mental health conditions. The way that healthcare is structured – often around single disease specialisms – can also be a disadvantage to those with complex and overlapping health problems. The system can struggle to see the whole person by treating each health condition separately.

For the people affected, as well as the families, friends and professionals who care for them, the impact of having multiple conditions can be life-changing. There are more appointments, with more doctors and nurses, as well as more drugs to monitor and manage. This heavy treatment burden, on top of living with the effects of disease can cause further stress and worry. But it is on the other aspects of life – like work, socialising, and doing things for pleasure – that people report the biggest impact of living with multiple conditions. As seen in the original case studies, small shifts in practice can make a big difference.

Summary findings

COVID-19 has upended all our lives but for **people with multiple conditions** the pandemic presents additional challenges. Across all the case studies revisited we heard how:

There is fear and anxiety from the increased risk to life from the virus for people with pre-existing health conditions and for some a sense that these health conditions mean their lives are less valuable in the face of COVID-19. As one practitioner put it “the way the death toll was reported for example, with the number of people dying and then the number of them that had long-term conditions, made many of our patients ask do people think it is okay to die from COVID-19 just because you have a pre-existing health condition?” For those affected by inequality, especially in BAME communities, these feelings of fear and anxiety are often amplified.

The restrictions in place to keep people safe, including for the 2 million people recommended to shield (many of whom have multiple conditions), mean that **people’s health conditions are, more than ever, affecting their ability to go about their life as normal**. Even shopping for food and picking up prescriptions is classed as ‘dangerous’ let alone seeing friends or joining an exercise class. For many people it has affected their ability to do their job as well as their mental health and wellbeing.

The disruption to the health and care services that many rely on to keep well – including access to regular appointments, clinicians or treatment – not only causes stress and worry but also a deterioration in people’s health. Practitioners report concerns that **many people have gone downhill**. For some this is literally life-threatening; others are now not well enough to benefit from wider practical and emotional support to improve health and wellbeing and face an uphill struggle to get back to where they were. On a more positive note there are also reports that the pandemic has triggered a change in mindset with some people more actively looking at ways they can improve their own health and wellbeing through exercise, diet, spending time in nature and more.

From **practitioners** we heard how:

Even with the risks and restrictions from COVID-19 many **people, professionals, communities and services adapted almost overnight**. New relationships and ways of working were quickly established. In many cases the development of place-based partnership working accelerated, deepened and expanded, to involve all, from neighbours to senior commissioners. All hope that this place-based partnership working becomes permanent and that the NHS takes the opportunity to be part of these community partnerships, rather than apart from them.

Digital and online technologies played, and continue to play, an important role in the transformation of services. Yet all practitioners caution against an over-reliance on this given the **inequality in access whether from a lack of skills, equipment, broadband and mobile coverage, or ability to pay for digital connectivity**. The good old-fashioned phone has proven a vital tool for many, with practitioners welcoming opportunities to develop new phone skills. For certain people, whether because of this lack of digital access or because of physical impairment, medical condition or safeguarding concerns, face-to-face always needs to be available as an option.

The wider social and practical needs of individuals with health conditions were recognised and addressed. **The interplay between people's social, economic, environmental and health circumstances has become pressingly apparent**. Recognising, for example, that without food nothing else really matters, a focus on sorting basic needs first was often taken.

The pandemic is driving practitioners to think more about how they can **address inequality by increasing access** to hardly reached groups, provide culturally and language appropriate support, and collect better data on ethnicity and inequality. Many are focusing on identifying, and working through, existing champions and organisations within affected communities, building partnerships and giving them a platform rather than trying to do everything themselves.

Like COVID-19, multiple conditions occur disproportionately within populations that are socio-economically disadvantaged, amongst people in BAME communities, older people, and particularly people within populations where these factors overlap. The relationship between our health and the conditions in which we are born, grow, live, work and age (the social determinants of health) is clear. It underlines the vast and growing health inequalities in our society, of which both increased risk from COVID-19 and increased prevalence of multiple conditions are symptoms. Reflecting this, all the case studies share a call for an approach to multiple conditions that is more practical and focused on people's social circumstances than purely medical.

We know from previous Taskforce research that this focus on the whole person and their real-life situation is important for people who already have multiple conditions. It is also important for people at risk of developing multiple conditions, and in terms of how we tackle the ongoing pandemic with a view to protecting the most vulnerable in our society. Looking back to the eight ingredients in the original Multiple Conditions Guidebook we see that these are more important than ever and remain the right place to start when thinking about a response. Although they may be harder to achieve in practice in the current circumstances, this does not mean we should not try. This matters especially as working to improve the lives of people with multiple conditions will also work to address health inequalities, which the pandemic has shown must be a shared priority for all.

Black Country

In the Black Country people with multiple conditions are supported to progress closer to work, training or education through the Bridges project. 15 local partners – including NHS mental health providers, the council and other charities – work with local charity **Steps to Work** as coordinator so support can be tailored as needed. The 2019 Multiple Conditions Guidebook described the approach in the Black Country in a [case study](#).



In Autumn 2020, the Steps to Work Deputy Partnership Manager, Gemma Calvin, updated us on how they had adapted their approach in light of the COVID-19 pandemic.

What did you do to provide ongoing support to people with multiple conditions during the initial COVID-19 lockdown?

As a project we made an early decision to move to remote working. This meant that by the time the country went into lockdown in late March our project officers were already using phone, email and video platforms like Zoom and Teams to work with people and organise the support they needed to move towards employment. Recognising the likely toll on mental health for people with multiple health conditions we assigned more staff to make wellbeing calls to all our participants. We also increased our social media presence, on Facebook and Twitter, to try and make sure anyone else that was struggling and needed support knew we were there.

How did the situation affect the people with multiple conditions that you work with?

As well as the impact on mental health, our participants with multiple conditions – most of whom were at high risk from the virus and therefore shielding – needed support in getting the basics such as food shopping. As time went on many were also confused about the guidance and needed help to understand new rules around social distancing and support bubbles for example.

What impact did you have during this time?

With everything that we set up remotely we were not only able to keep working with our existing caseload but we also had new people approaching us for support. Whilst we had to stop all face-to-face contact until recently, most project officers reported that their interaction with people had actually increased and they were busier than usual because participants needed a friendly point of contact to get them through the pandemic. Some project officers also reported that the participants were calling to check they were okay. This demonstrated to us the strength of relationship built between project officers and participants.

“We really felt the benefit of being in a partnership with so many other organisations during this time.”



Was there anything in particular that you think helped you achieve what you did?

We really felt the benefit of being in a partnership with so many other organisations during this time. All our partners were brilliant at sharing ideas and raising awareness of external support, such as COVID funds that participants could apply for to add to what we were doing. Our funders were also incredibly supportive throughout and gave us guidelines almost on a weekly basis to support the ongoing delivery of the project. Credit must also go to our participants, who by and large transitioned to remote working very easily.

“The importance and inequality of access to IT was very apparent during lockdown.”

What challenges did you overcome?

The biggest challenge we had was supporting participants who were not skilled in IT or who did not have access to the necessary equipment. The importance and inequality of access to IT was very apparent during lockdown. Some of our partners purchased more specialised equipment to support participants as they moved to remote working. For our project officers, if IT was an issue then they had to complete their sessions over the phone. We also purchased a lot of personal protective equipment (PPE) to allow the project officers to go to participants homes,

staying outside and socially distant, but dropping off activity packs to keep them engaged in the programme or food parcels if required.

Where are things now in terms of the support you are providing and what do you think the future holds?

We are now working with a hybrid model which mixes both remote working and face-to-face sessions, based on the preferences of the individual we are working with. We are also, though, planning ahead for further restrictions. We have created lockdown packs. These are full of activities like mindfulness and colouring, some PPE, and useful contact numbers. These are to help people to return to face-to-face support if they want it, but they can also be used should a participant need to self-isolate or experience any periods of illness. Our aim is that whatever happens people can still remain involved and engaged with the project.

One thing that we have found in the past is that the NHS can struggle to signpost to others in the community who could contribute to the work they do. Many of our participants with multiple conditions are affected by this lack of integration. We hope that our model of working in partnership, including with NHS partners, will help to demonstrate how interrelated all our work is and that by working together we can help prevent overload of the NHS system which in turn can then fail people with multiple conditions. From what we have seen COVID-19 too is adding to this need to work more closely across the NHS and in communities so we hope this may produce a positive outcome in the longer term.



Spotlight on inequalities

The Black Country is within one of the more diverse regions of the UK, with one in five people part of a Black, Asian and minority ethnic (BAME) community. It was once an area of heavy industry with coal mining, brick-making and steel works. The high unemployment that came with the decline of these industries has created some of the most deprived neighbourhoods in England.

Statistics show that the Steps to Work Bridges programme has always proportionally given additional time and support to BAME communities. This is partly because of the high levels of health inequality in those communities. To better address issues of inequality Steps to Work has just received approval from their funders to recruit four community champions to work across the partnership. Two of these will focus solely on the BAME communities.

For Natalie, a Bridges participant supported by Just Straight Talk (JST) to build her confidence, manage multiple health conditions and develop her computer skills, COVID-19 made her feel at high risk given the figures concerning people from BAME backgrounds. This led to further deterioration in her mental health and increased isolation. To help ensure the progress she had previously made would not be lost, JST supported Natalie to join her craft and other groups

online. They also helped Natalie access the local COVID-19 resilience fund to get money for food, including from the local fish and chip shop as a treat. Natalie felt overwhelmed by this kind gesture and how the community had come together in hard times. "It really brightened my day," she said. Natalie is now exploring with JST how she can become an Ambassador for BAME communities and pass the gesture on and organise events for the community when it is possible. For Natalie, it is this community spirit that made the difference to her.

"I am positive we can overcome COVID-19 together as a community"

- Bridges participant, Natalie

With community champions like Natalie, Steps to Work hopes to be able to make a difference to people from BAME communities and reduce health inequalities. They are also thinking about different ways to help people access the IT equipment and skills they might need during continuing restrictions and disruption to everyday life.

Shirley's story

Steps to Work and its partners on the Bridges project have provided support to people with multiple conditions above and beyond helping them move towards employment. This has been hugely appreciated by the people they work with as demonstrated by the many testimonies on social media.

As part of this review we heard from Shirley, who has a cancer diagnosis and poor mental health. For over a year Bridges has been supporting Shirley to overcome her barriers to employment from her physical and mental health issues, lack of computer skills and bereavement from the loss of her partner.

"It has been a lifeline. There was no way I would have been able to get the food supplements home without their help,"

- Bridges participant, Shirley

Whilst she was making good progress, COVID-19 has been incredibly challenging for Shirley. She has no family support local to her as they all live in Scotland and due to her physical health issues she had to isolate at home. During this time Shirley had her feeding tube removed, which marked a significant milestone in her cancer treatment. As swallowing is still difficult her GP prescribed a liquid food supplement. However due to a lack of delivery slots the local chemist told Shirley she would need to come and pick up the 120 bottles herself. Without transport this was impossible for Shirley. Recognising that without food no amount of computer skills would help, JST collected and delivered the 120 bottles to her door. For Shirley this practical help made all the difference and ensured she had the food she needed.



British Lung Foundation

The British Lung Foundation (BLF) has a network of volunteer-led local support groups across the UK for people with lung conditions, 90 per cent of whom have multiple health conditions. Around 100 groups offer sessions with healthcare professionals and wellbeing advice, as well as weekly opportunities to come together for exercise and other activities. Further detail about the BLF Support Groups was originally set out in a [case study](#) in the 2019 Multiple Conditions Guidebook and discussed during a follow-up [webinar](#).

In Autumn 2020 we heard from the BLF's Head of Support Groups, Petra McCauley, about how COVID-19 had affected the groups and their participants.

How did the COVID-19 pandemic affect the support you offer?

As a charity focused on respiratory illness, we knew from an early stage the pandemic would have significant implications for our beneficiaries. We asked our team of medical advisers to get together and brainstorm likely scenarios. Face-to-face support was not an option in the short term given the majority of people we work with are considered extremely vulnerable to the virus. So, everything had to stop. This included all the existing support groups as well as the rollout project for developing new groups.

What impact did you see on people with multiple conditions?

Understandably, with COVID-19 being classed as a respiratory condition we had, and continue to have, a lot of very anxious and confused people on our helpline and in our groups. However, people's concerns have changed over time. In the beginning we had a lot of queries about shielding, what to do when important clinical reviews or appointments were cancelled, how to access GPs and medication, and safety in the workplace. It was difficult for everyone involved because you want to be able to help clarify and reassure people but often there was no clear answer. More recently we have had a lot of people with concerns about face masks and eligibility for flu jabs.

Now we see anxiety levels rising again as the numbers of cases increases. And a lot of people are clearly suffering from the social isolation that comes with needing to stay at home more, especially in the winter months.

Did you manage to provide alternative forms of support?

As a team, once we knew the implications for face-to-face support we quickly started to try and bring the existing groups up-to-speed technology-wise. Obviously some of our volunteers knew what they doing. They already used things like FaceTime and Skype to communicate with family and friends but not many had used Zoom. I certainly never envisaged organising a Zoom meeting with breakout rooms.

We started holding quarterly events for the volunteer group leaders. In these sessions we have a balance of the latest information on COVID-19 and how to manage different respiratory health conditions, what's happening in the wider work of the charity, maybe a speaker but then time to go into breakout rooms for a discussion, which may be about something specific or just a general catch-up.

Our project officers also talked volunteers through the technicalities – like how Zoom works, how people can access it through a phone line, and how to stay safe online. They would then go to the first few meetings to help out before leaving volunteers to run with it.

We were due to have our annual national conference for our group leaders during Volunteers Week in June but we transferred this to an online conference.

Many of the groups have gone on to provide regular opportunities for their members to come together online. Online exercise classes have worked well. And the people in the groups have been really inventive. One person did a long sponsored walk around her garden as a fitness challenge and fundraiser.

“People are clearly suffering from the social isolation that comes with needing to stay at home more, especially in the winter months.”

Did you see any positives from the shift to working online?

We have seen an increase in the numbers of people attending events online as well as new connections being made. For example, at our annual conference we were expecting about 60 volunteers to attend in person but over 90 joined virtually representing 60 support groups. It was fantastic to watch. It was a real social occasion rather than a formal business event. We have seen volunteers from Scotland linking up with others in Norwich and people being free to join whichever group they want as they are not geographically constrained anymore.

For us as a team it has also brought a lot of positives. We are a small team in a national organisation but we are finding that with the shift to online working we are able to reach out to people more than ever before. Now we know what nearly all our volunteers look like whereas before much of the communication was done by email or over the phone. We can also pop in and join events easily so it is much easier to support groups with speakers and share information. It has also really built rapport between staff and volunteers. We have all been learning together so there has been a level playing field. Some volunteers were really worried about running events online but they have seen things go wrong when we have had technical glitches and it has helped reassure them and build confidence.

One thing we did not expect was how uplifting it would be to help people get online. People are really delighted and surprised at themselves when they manage to do it. And they really enjoy the breakout rooms and opportunity to chat to others. We have been trying to encourage our volunteers to get to know each other for years and it is now really happening.

What challenges did you face?

I do not think any of us realised how exhausting it is to work online all the time. We are learning now about the right length of time for sessions and groups. They have to be shorter than face-to-face events because of the intensity but this seems common with what other organisations are experiencing too.

However digital access, the lack of it, is the biggest issue. There's an element of this that is around helping people develop the necessary skills and overcome their distrust of the digital world to be able to join in virtually. We can and do help with this. We are always there to help our volunteers join our online meetings. It is important we are there, and we like to help, but it is labour intensive. But there's another element to it, where people are excluded on financial grounds. This is a much bigger problem than we as one organisation can tackle.



What do you think the future holds for your work?

With the pandemic ongoing there are lots of things that are still continually changing. We are thinking about how we manage that going forward. Back in March, for example, we were very hands on with volunteers and members. Then everyone was very enthusiastic and engaged. But once we came out of lockdown, we lost people as they returned to a more normal life. We are trying to find ways to motivate people to keep going and see how we can remain responsive to a fluid situation.

In the future we hope to continue with regional and national networking meetings virtually. We have found it is the best way to meet people across the country. However we would like to still have two opportunities a year for people to meet face-to-face. For us a blended approach seems the best way to go. Now that we understand the differences in online and face-to-face events we plan to keep making improvements. We have found that it works better online to be a little less prescriptive and more free flowing than at face-to-face events, and also to allow for a greater element of creativity. We have also realised that we have more capacity as a team for online events and they are less time consuming to organise and facilitate than we originally thought. Previously when volunteers have asked if we could do monthly get togethers we were nervous about capacity. But now, and especially over the winter months, we are going to try and do that.

Spotlight on inequalities

Lung disease is a major factor in widening health inequalities. Chronic Obstructive Pulmonary Disease (COPD) and asthma are more prevalent in more deprived communities. And there are significantly higher rates of asthma in BAME communities.

Currently there are no specific BLF Support Groups for people from BAME communities but the team are currently looking at how they can address this. They are hoping that with increased use of digital that they can diversify the people they meet, for example by taking up opportunities to join existing networks and connect with more varied community groups.

The impact of inequality on digital access is something that the team have experienced first-hand. A number of group leaders were already technologically savvy before the lockdown but then they completely dropped off the radar. For Petra and the team this was a bit of a puzzle, but they discovered that they had been using computers at their local library and with lockdown they lost this access.



“Chronic Obstructive Pulmonary Disease (COPD) and asthma are more prevalent in more deprived communities. And there are significantly higher rates of asthma in BAME communities.”

Peggy’s story

Many people living with a lung condition are affected by complex health issues. Daily life can be a struggle. With the heightened risks and restrictions from COVID-19 this has been even more true. We spoke to Peggy Allison, a British Lung Foundation volunteer who is the secretary of the local support group in Chorley and South Ribble.

Peggy is 76 and has multiple health issues including asthma, COPD, type 2 diabetes and heart problems. Whilst Peggy has mobility issues and needs ongoing care and support from her husband at home, she is normally kept busy keeping up with her family, including seven grandchildren and two great-grandchildren. She has been a scout leader for 46 years and enjoys helping others with health problems through the BLF support group.

“I can talk to them through the window but that’s it. I cannot wait for the day I can hug all my grandchildren and great-grandchildren again.”

- Peggy

When Peggy heard the news of COVID-19 she quickly shared her decision to isolate with her family. During lockdown her husband would still go and get the shopping every few weeks, but otherwise they did not go out. As secretary of the local BLF Support Group Peggy has kept in touch with the other members through monthly emails. In these emails she shares their news with the group. “I want to encourage others in the group to try and find a hobby and keep their minds as active as they can. I share with them what we have been doing. For me I am always knitting but I also enjoy playing card games on the computer. My husband tends to the allotment which the group always benefit from so I like to let them know what is happening there.”

Family is very important to Peggy and whilst her son and daughter live nearby it is hard to not be able to see them properly. “I can talk to them through the window but that’s it. I cannot wait for the day I can hug all my grandchildren and great-grandchildren again.” For now, though, Peggy is still largely avoiding any contact with others. “I have been for an eye test and to the GP surgery car park for a flu jab but that is it. I really do not want to risk going into the surgery.” For now Peggy and her husband are finding their hobbies and interests are keeping them busy and trying to help others in a similar situation to do the same.

Cornwall

In Cornwall, recognising that there is no ‘one size fits all’, people with multiple conditions have a choice of services to encourage self-management. These are offered in different formats ranging from condition-specific information, personalised care and support planning, social prescribing, peer support groups and psychological and emotional support. The approach taken by public health officials to co-design this model with patient representatives and others was summarised as a [case study](#) in the 2019 Multiple Conditions Guidebook.

In Autumn 2020, to understand how this is working in practice for people with multiple conditions, we spoke to a volunteer at the social prescribing project in St Austell. Social prescribing, which links people into activities and support to improve health and wellbeing, has benefitted over 1,400 people in St Austell, many of whom have complex health issues.

Sharon, now a volunteer, was originally supported by this social prescribing team to help with low mood after a type 2 diabetes diagnosis and living with pain for years caused by hip dysplasia and subsequent surgery. Amongst other things, a diabetes support group really helped Sharon, so much so that she ended up becoming one of the volunteer leaders of the group. We asked Sharon about her experiences and how COVID-19 had affected her and her work as a volunteer.



“The social prescribing team and the council were able to organise food parcels, but I also took people bits and pieces to help – like low-carb bread and sugar free cheesecake.”

Sharon - Volunteer at St Austell Healthcare



Can you tell us about your work as a volunteer before COVID-19 hit?

I did not really set out to be a volunteer but one of the younger volunteers that ran the diabetes support group left to go to university. Many people in the group suggested that maybe I could take over. I was not sure I could do it but one day Hayley, the social prescriber, came to the group. She encouraged me and gave me the confidence to do it. I am not an expert but I put my diabetes into remission and thought that my experience could help others. I taught myself quite a lot about the disease and I have a background in social care so it all came together. I work with another volunteer and we used to run sessions twice a month.

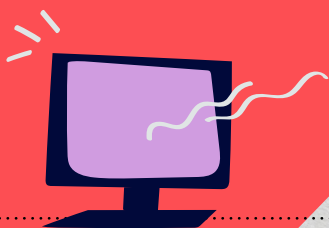
“I am not an expert but I put my diabetes into remission and thought that my experience could help others.”

What happened to the group when COVID-19 hit?

During the first lockdown everyone was really upset when the support group meetings had to stop. I had an idea about doing it online, which we proposed to Hayley who supported us to do it. It took an awful lot of effort to get people online but after trying a couple of different platforms we managed to get between five and eight people online at least once a week and sometimes more.

What impact did you see on people during this time?

I have seen a massive impact on my own life from COVID-19. With my health issues I was too scared to go out and even when lockdown lifted I was cautious because of all of the tourists. A lot of people get very lonely and really miss the opportunity to get together with people. To help with this we started also offering a social quiz every other week on top of the support group sessions. This went down really well. The group also really love seeing my granddaughter on the screen. She is two years old now but has been accompanying me to the support group since I started volunteering so the group has seen her grow from a baby. Some people were in a bad situation – waiting for benefits and not able to get food. The social prescribing team and the council were able to organise food parcels, but I also took people bits and pieces to help – like low-carb bread and sugar free cheesecake.



What helped you keep going?

I knew from early on that I was going to need some support myself. I know from my own experiences that just talking with other people helps. COVID-19, and the lockdown, was obviously quite isolating. I am lucky as I have my children nearby, but you need your friends and other social interaction in life. In this regard setting up the group online probably helped me as much as it helped others. Also meeting Prince Charles and Camilla in July, when they came to visit the surgery and hear about our work, was a great encouragement.

I also found the local social prescribing Help-at-Hand app absolutely brilliant. I have recommended the app to lots of people. When lockdown lifted I found a chair-based exercise class for the over-50s. Our diabetes support group was also the guinea pig for a trial of a six-week health and wellbeing coaching course delivered by a former GP. We had sessions on things like sleep, meditation and mindfulness. This really helped.

What challenges did you have to overcome?

Access to technology is a big issue with a lot of compatibility issues between different brands of tablet and things like Zoom. For some tablets we just cannot get it to work. One lady has a PC that is really old. It took us an hour and a half on the phone to get it set up, but we did it. For other people they just do not have the confidence or skills to get online, or the equipment. This is the biggest issue. If there was a simple affordable tablet that had Zoom built-in that would be great.

“I really like to see people as I think it is important to have human contact. But the online option is convenient so in an ideal world I would have both.”

What would you like to be able to offer in the future?

Personally, I really like to see people as I think it is important to have human contact. But the online option is convenient so in an ideal world I would have both. Normally we meet face-to-face twice a month so I am hoping we can continue online on the weeks in between. We cannot cover the hall hire to meet face-to-face more regularly and people are now used to having something once a week so I would not want to take that away if possible. When you have not got a lot going on people need regular opportunities to get together to keep them going.

Gateshead Year of Care

In Gateshead, GPs offer people with multiple conditions a combined annual health review with care and support planning driven by what matters to the person involved, and their concerns and questions. The approach, which was developed and is supported by the [Year of Care Partnerships](#), has been in place for over three years. It was originally detailed as a [case study](#) in the 2019 Multiple Conditions Guidebook and discussed during a follow-up [webinar](#).

In Autumn 2020 we spoke with Gateshead GP Dr Rebecca Haines to find out what the events of 2020 had meant for her work and, more importantly for her patients living with multiple conditions.

How did the initial phase of the COVID-19 crisis affect the support you provide for people with multiple conditions?

We were hit hard and early by COVID-19 in Gateshead which meant that the hospitals were very busy. At the same time for a short while GP surgeries were oddly quiet. Initially we had to put lots of things on hold as we worked out how to provide ongoing healthcare in a safe way. This included our 'call and recall' system for annual health reviews for people with multiple long-term conditions. But within the first month of lockdown we realised that the virus is not going anywhere soon and if we did not restart our ongoing system of care for people with multiple conditions, in a way that was COVID-secure, we would never catch up.

How did you adapt your approach?

We approached the Year of Care Partnerships team to see if they could adapt their system of care and support planning to suit a COVID-19 world. This included bringing in greater use of telephone or video consultation, increased home monitoring and a triage system to determine which approach was most suitable for patients. One thing that we did not do was completely abandon the option of seeing people face-to-face. Anyone with a clinical need was invited to see our healthcare assistant or nurse for their information gathering appointment.

However we also did not force people to come into the surgery as understandably many people were nervous of leaving their homes. For some patients, for example people with dementia, hearing impairments or English as a second language, using the phone or video has obvious challenges. In these instances, we offered practice appointments or home visits with personal protective equipment (PPE) We encouraged the use of video to explain things where possible, for example starting new injections or the correct technique for using an inhaler. But overall the bulk of our reviews were done over the phone.

“We realised that the virus is not going anywhere soon and if we did not restart our ongoing system of care for people with multiple conditions, in a way that was COVID-secure, we would never catch up.”

What helped you during this time?

We are lucky locally as our clinical commissioning group (CCG) and public health officials worked collaboratively from the get-go, across the health and care system from the hospitals to primary care, with the council, care homes and public health. Really in many ways it was as good as it could have been.

We worked with Year of Care to develop new protocols and procedures for our approach with multiple conditions patients, but they also provided training resources for how to conduct phone consultations. This was helpful for the wider practice staff, as while many GPs are used to doing consultations on the phone, some practice nurses and nurse practitioners are not and had requested training to build their confidence. Many of our patients were aware the NHS was under pressure so initially did not want to take up our time. We worked hard to make sure that people understood we had the time to give them.

“The way the death toll was reported made many of our patients ask do people think it is okay to die from COVID-19 just because you have a pre-existing health condition?”

What did your patients with multiple conditions report?

Obviously a lot of our patients were understandably very frightened and even for people who were managing well, it was pretty horrendous. The way the death toll was reported, for example, with the number of people dying and then the number of them that had long-term conditions, made many of our patients ask do people think it is okay to die just because you have a pre-existing health condition?

For our younger patients particularly, for example people with type 1 diabetes, suddenly being labelled as high risk had a negative impact. For many, they had never really thought about being in ‘ill health’, but suddenly they see themselves in that way. And for some, with the restrictions, it was hard to escape the way that their condition now affects their daily life including their ability to go shopping for themselves, work and meet up with family and friends.

“For our patients with multiple conditions we really struggled to find relevant guidance.”

What challenges did you overcome?

Managing the ever-changing and developing guidance and policy was a challenge for anyone on the frontline. But for our patients with multiple conditions we really struggled to find relevant guidance. There was lots of good stuff, from the NHS and condition-specific charities, with advice for people with a particular health condition like asthma or MS, for example. But for people, for example with asthma, MS and diabetes, it was really difficult to work out the hierarchy and which bits of which advice and guidance were most relevant. For us it meant that we had to review each and every patient individually to consider their hierarchy of needs. In some ways the approach became even more personalised. But it would have been helpful to have more brains thinking through the issues from the perspective of multiple conditions. I believe that if we can get the advice and guidance right for people with multiple conditions then it will, by default, work for all people with a long-term condition.



“COVID-19 might end up being a driver of change, resulting in more active personal management of health and wellbeing.”

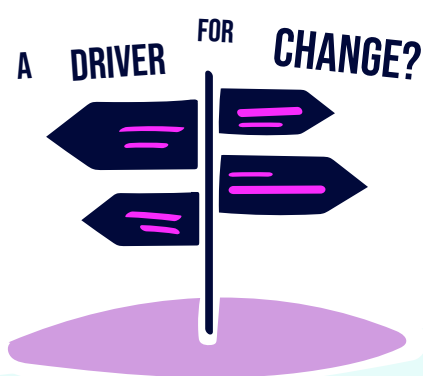
In the short term, what do you think the future might look like for people with multiple conditions?

Obviously it is still an incredibly worrying time for anyone with existing long-term health conditions, but I can also see some potential positives. There were quite a few of our patients who had not wanted to change anything in the management of their multiple conditions for years and are now focused on improving their health as best they can. In a perverse way, COVID-19 might end up being a driver of change, resulting in more active personal management of health and wellbeing.

Thinking about the eight ingredients that were identified in the original Guidebook I think COVID-19 has really emphasised the interplay between the medical conditions people have, who they live with, whether they have support, what they can do for themselves in terms of wellbeing, what their job is, and how their mental health is. I think all of us now have a greater real life understanding of how all these things have such a huge impact on our health. Someone might cope very well with their health conditions but their job might impact their mental health which then affects things in a negative way. As a professional, it has made me more determined to change my focus completely to understanding who the person in front of me is.

“As a professional, it has made me more determined to change my focus completely to understanding who the person in front of me is.”

- Dr Rebecca Haines



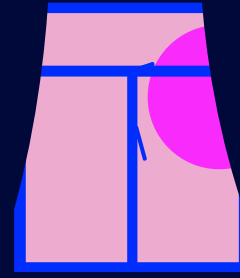
Spotlight on inequalities

In Dr Rebecca Haines' GP practice, like the North East as a whole, patients are predominantly white British. But for their black, Asian and minority ethnic (BAME) community, the key issue that has come up during the COVID-19 pandemic is around language. In the surgery they have an interpreting service, which is accessible for face-to-face appointments. But using an interpreter over the phone is much more difficult, especially as it doesn't allow for the visual and behaviour cues. It also takes double the time so only half the number of appointments can be scheduled. The CCG is working with practices to improve the collection of data on ethnicity of their patients, as this is another challenge faced. Over the next four months GP surgeries have also been asked to prioritise BAME patients who have long-term conditions and are due a health review.

Gateshead is an area of great deprivation and before COVID-19 there was already a lot of work going on with public health to try and address the health inequalities that are driven by this. During COVID-19 Dr Haines

found that the inequality in digital access was the biggest issue and some people even struggled to access a phone let alone have the capability or ability to pay for data to have a video consultation or send a photo. To overcome this, the surgery kept options for face-to-face and home visits open, but Dr Haines feels it is something that needs to be thought about at a policy level if ongoing restrictions continue over the longer term.

“Using an interpreter over the phone is much more difficult, especially as it doesn't allow for the visual and behaviour cues.”



“It is harder now, at this time of year, because of the dark nights. You really don’t get to see anybody, especially if you are on your own.”

Norma’s story

In Gateshead there are higher rates of cardiovascular disease, diabetes and respiratory illness than the national average. This puts many in the local population at increased risk from COVID-19. We spoke to Norma Stewart, one of Dr Haines’ patients, about the impact the pandemic has had on her life and what it has meant to have ongoing access to her GP. Norma is 72 years old, lives alone, and amongst other conditions has asthma and type 2 diabetes.

Before the pandemic Norma had an active life. She led the chair-based exercise class at the local community centre, played a key role in her local church and enjoyed walks with friends in the local area. She told us: “Keeping active is really important to me, especially as for most of my illnesses you need to keep moving.”

As news of the pandemic started to hit, Norma was worried. “The announcements kept saying it was a problem for people suffering from diabetes, asthma, heart conditions and the over-70s. I tick all these boxes so I started thinking there’s not much hope for me. It was a bit scary.” But Norma’s neighbours quickly insisted on doing her shopping and she set about keeping herself busy at home. “I thought now is the time to clean out the cupboards, so I did a job a day. Then maybe a jigsaw or a crossword to keep my mind occupied. Even though I could not go out I would walk up and down the stairs, or up and down the path to my gate. I got myself into a bit of a routine. I had to accept the situation. But it was hard at times. The only family I have now are my brother and his children in Canada. They rang me once a week through lockdown. And me and all my friends would ring each other up for a chat.”

Around May Norma’s chest worsened. She spoke to Dr Haines over the phone who quickly arranged for an examination and tests, which confirmed it was Norma’s asthma rather than anything else that was causing the problem. Norma has also had her regular health reviews over the phone. For Norma the ongoing access to her GP has made all the difference. “I didn’t want to put the doctors to any trouble, but Dr Haines and the other GPs have really given me excellent treatment. I know if I have any problems, I can ring them on the phone.” Whilst some of her hospital appointments have been postponed because of the backlog from the first phase of the pandemic, Norma has been able to get exercises to do at home from her physiotherapist. This has helped her to keep on top of things but she is keen to be able to see the physio and the GP in person. “At the minute, without the phone calls, I’d be sitting here in a pretty worried state. But nothing beats face-to-face.”

Thinking back to August, Norma reflects on the impact of staying indoors for four months. “When it was safe to go out again, it was really difficult the first half a dozen times. I had to give myself a real talking to and just get cracking.” Norma was just getting back in the swing of things, helping out at the community centre, when the North East went back into restrictions in September. Whilst she hopes that things may ease by Christmas, she is preparing herself for ongoing restrictions throughout the winter. She has cancelled her usual plans to spend Christmas with friends, but she is looking forward to soon getting a tablet from her nephew. With some help from her neighbour to set it up she is hoping that it will mean she can have a video call with her brother and his family on Christmas Day. “It is harder now, at this time of year, because of the dark nights. You really don’t get to see anybody, especially if you are on your own.”



Total Wellbeing Luton

In Luton, a specialist team of exercise trainers organise tailored support for people with multiple conditions who want to improve their physical and emotional health. There is a menu of options, from a range of partners, including specialised exercise classes and rehabilitation as well as things like weight loss programmes, talking therapies and gardening. The Multiple Conditions Guidebook profiled the Total Wellbeing Luton Service as a [case study](#) in 2019.

In Autumn 2020 we spoke with Sarah Simmonds, Total Wellbeing Luton's Health Specialist Manager for long-term conditions to understand what impact the past year has had on their programme and the 500 people living with multiple conditions it supports.

How have things changed for your service with the COVID-19 pandemic?

As a wellbeing centre with a gym we had to follow the government guidelines for gyms more generally and completely close in the first lockdown. Then, because Luton was hit with a second spike in early summer it was mid-August before we were able to open again. This meant we were closed for nearly five months. We had to furlough the majority of our employees, making us very short-staffed.

Did you manage to offer any alternatives during the period of lockdown?

We did what we could virtually. We used our [Total Wellbeing Facebook page](#) and set up a [Total Wellbeing Luton YouTube channel](#) where we posted videos every week on different aspects of fitness for people with health conditions as well as daily live sessions from our trainers about fitness more generally. We hosted regular [webinars](#) to provide wellbeing support on topics like sleep and managing worry. We offered coffee mornings for our clients on Zoom. We also contacted people over the phone and directed them to the support we knew was available online from our partners. In August, as soon as the Government said it was safe to do outdoor training we started to put on specialised training sessions for our clients.

What impact did you see on your clients with multiple conditions?

We saw, and continue to see, a lot of anxiety and fear. Obviously because most of our clients are in the high risk category they were nervous of attending centres like ours, even when we started offering outdoor exercise sessions. On the plus side many of our clients started walking and cycling so whilst they are not coming to the centre they are still being physically active.

We work with a lot of older people and not everyone has the technology or ability to access things like YouTube, Webex and Zoom. Some of them got left in the dark and there was nothing we could do. Where we could we provided support through the phone, often with a family member who could talk them through it, but it was a bit of a struggle.

The other impact we have seen is that some people have not been able to access their normal treatment and care for their health condition, so they have gone downhill, some of them to a point where they are not well enough to come back to our service. This is obviously very distressing for people, especially when it is for things like cancer, where delays in treatment can literally be life-threatening.

Is there anything that you feel could have helped you during this time?

It is a difficult balance for the Government, but I do think they should have opened up wellbeing centres earlier on. The health and wellbeing of people is just so important. For weeks pubs were open, but gyms were not. From our perspective we have seen how the closure of gyms and services like ours has affected so many people. And not just physically, but also people's mental and emotional health. We worked really hard to put things in place to allow people to return to the centre safely, but after such a long time of being closed people were understandably nervous.

“Many people with multiple conditions, especially cancer and respiratory illness, are still too scared to return to centres like ours.”

How do you think the programme will be affected in the longer term?

We are now halfway through our five-year contract but we are effectively starting again. Many of our existing clients dropped off the programme during lockdown, and we only have 50 per cent of them back. For example, in March we had 45 people on the programme seeking physical activity to support their mental health, in August we only had 21. Many people with multiple conditions, especially cancer and respiratory illness, are still too scared to return to centres like ours. We worry that they will never return and therefore not benefit from the additional practical and emotional support we offer improve health and wellbeing. We are looking into an online only option for people who are too worried to return.

Our model is based on referrals from healthcare professionals and these have dropped off a cliff. We are working closely with the respiratory teams, including for post-COVID rehabilitation, but they are not yet ready for the support we offer. Our approach is also based on working with others and lots of other services locally still have not opened. For example, all the council's dementia services are not opening until January at the earliest. Where we can we are trying to fill these gaps and provide additional support ourselves but it's not easy.

In the short term is there any learning you think might be helpful for people living with multiple conditions?

One thing that all this has made us realise is that we can do a lot more online. Our live sessions with an instructor have worked really well. And that's something we are going to carry on doing. We have found this has worked especially well for people that have children or are working at home. This was a gap in our area but 30-40 people signed in every day. I think if there are further lockdowns we will push the online thing more – and particularly see how we can increase access and tailor it to our clients with health conditions, including through chair-based activity. First time round we did a huge amount of preparation for people physically returning to the centre. We were expecting an influx, but it did not happen. In the future we will avoid spending money on preparing for a rush of people coming through the door and push the online thing a lot more.

Another thing we have noticed is that COVID-19 is driving officials and professionals to focus a lot more on prevention. There are a lot more discussions locally about how to find ways to increase support to people to maintain a healthy weight, stop smoking and be more active for example. This could have a long-term impact – both in terms of managing existing multiple health conditions, but also in helping prevent them developing in the first place.



We have noticed that many individuals have changed their outlook. People have realised that they can quite easily look after their health and wellbeing, outside in nature. Now this is not necessarily great for us as an institution, but a lot of people are enjoying their time cycling or walking and exploring new places around Luton. This is helping their physical health and mental health, which in the grand scheme of things is really positive.

“COVID-19 is driving officials and professionals to focus a lot more on prevention.”

One thing that we still need to focus on is helping GPs understand what is out there in the community, including our service. For example, we see the demand for mental health support from people with multiple conditions is going up at quite a rate. We know exercise has been proven to be as effective as some anti-depressants. At the same time we also know some people benefit from support and advice to become more physically active, especially if they have multiple conditions and they are not sure what they can do. Yet levels of referrals from primary care are lower than we would hope for. We need to find a way to let all the local GPs know we are here, so they can refer their patients with multiple conditions to us.

Spotlight on inequalities

Luton has a diverse population with a significant Black, Asian and minority ethnic (BAME) community. In the first years of the programme Total Wellbeing Luton worked hard to try and engage the whole community. The team attended community events and festivals and gave talks at different venues, like mosques, about the programme.

However this did not result in brilliant uptake from the BAME community. Since staff started to return from furlough this has again been an area of focus with outreach events taking place in October. There are plans for this to continue as and when the situation allows.



Bertie's Story

In Luton 37,000 people have a long-term condition, which means nearly one in five people are at greater risk from COVID-19. To understand the impact of the first lockdown and closure of the Wellbeing Centre on people with multiple conditions in early October we heard from Bertie, who has respiratory conditions.

For months Bertie was unable to go to the gym, which he usually did three times a week. Bertie really noticed an impact on health and wellbeing but whilst he was keen to get back, he also had concerns about safety when the centre reopened after the first lockdown. “My biggest concern was that there would be loads of people in the gym, bringing the virus in with them. But since I have been back the way they have laid everything out has been brilliant. There’s not too many people and it’s very clean. My advice to other people like me would be to get back here as fast as you can to improve your mental health and wellbeing.”



Southwark

In Southwark, navigators from Age UK Southwark and Lewisham work with people with multiple conditions to link them into local services and community-based activities like talking therapies, fire safety checks and singing groups. This voluntary sector-led social prescribing scheme was outlined as a [case study](#) in the 2019 Multiple Conditions Guidebook. Its success in Southwark led to the set-up of a similar scheme in neighbouring borough Lewisham.

In Autumn 2020 we spoke to the Southwark Navigation Project Manager, Syeda Hussain, to understand what has happened over the last year and the impact of COVID-19.

How have things changed since the publication of the Multiple Conditions Guidebook?

Over the past year we have expanded. We secured funding to provide extra support over winter. This meant that in addition to working with GPs and in the community we could also support people leaving hospital, those using the falls alarm service for other purposes, and frequent users of A&E. This funding was then extended until July to cover the initial phase of the pandemic.

We are also changing the way we work and are in the process of setting up a community hub to work alongside our navigators in GP surgeries. This hub, based in the Southwark Resource Centre with the council, will partner a variety of organisations including the South London Carers, Southwark pensioners, Time and Talents, Link Age and others to provide a one-stop shop. This means that individuals can go to any of the partners to receive the same level of support from the service, which is called Ageing Well. At the moment it is telephone support, but we are looking into resuming office and home visit appointments as soon as we can.

How did COVID-19 change how you work?

Given who we work with, older people with multiple health issues, we stopped all face-to-face contact early in the pandemic. However we knew that many of our clients would have additional needs so we called everyone over the age of 68 we had been in touch with over the

last two years. This was over 2,000 people. The biggest demand people had was for food, followed by prescription collection and fears of isolation. We connected a lot of people up with befrienders, as well as for food and prescription deliveries, but we ourselves continued to call about 400 people once or twice a week. There were some people that we could not reach on the phone, so for these we sent out a letter. This had quite a few responses. We also sent out activity packs with things like mindfulness and chair-based exercises, and provided free slippers as part of our falls prevention initiative

What impact did you see on people living with multiple conditions?

Overall we found people really missed human contact, especially with their friends. But we saw a real mix of situations and reactions. For some people – especially those who had sensory impairment or lived alone – having someone, like one of our navigators, that they knew they could turn to was important.

“We found people really missed human contact, especially with their friends.”

Things also changed over time. For some people the anxiety about not knowing what was going to happen got worse and many suffered with cabin fever. For others when the government guidelines changed, they were still too scared to go out. Some people started off okay but as their financial situation got worse or they could not get to the bank to get cash, then things deteriorated.

What specific challenges did you overcome to provide ongoing support during this time?

A lot of our clients are not able to use the Internet so this was our number one challenge. To help overcome this, in June we signed up with Hubbub's smart phone donation project. Our handy person services and Food 2 You helped deliver the phones. Then we had DBS-checked volunteers from GoodGym who visited older people at home and help them set it up. This worked for us as older people often feel happier with volunteers that have been fully vetted.

Another issue we had was we could not easily assess people's homes. We were left having to ask questions over the phone, which can be limiting. To address this we changed our communication style. Instead of asking standard questions or following a script we explored things through conversation, a bit like in detective work.

Processing paperwork was another issue. This was particularly problematic on the financial side of things. There are limits as to what you can do over the phone without the right paperwork and with GDPR you cannot do it online. This affected people's ability to get transport too, for example the paperwork for dial-a-ride became a problem. We are currently looking at different ways of collecting and processing paperwork.

which made it unclear as to whether it would be safe to resume home visits. For safeguarding concerns, we relied on social services. Sometimes this was right and there was a clear social care or safeguarding need. But it was not always appropriate and we did not want to overload them. One of our partners, Time and Talents, did start doorstep visiting so we worked closely with them and between us tried to make sure that everyone that needed support in the local area could get it.

Better funding would have helped. Funding calls were either too broad or too specific and in some cases it created a competition between organisations supporting different vulnerable groups which was unhelpful. In our experience it would have been better if funding was issued according to need, for example for digital inclusion or access to food.

“We found that our local partnership worked really well. Everyone came together around a person.”

What worked well?

We found that our local partnership worked really well. Everyone came together around a person. Our role was to do the casework but then we relied on others to provide different types of practical support. Before COVID-19 there were strict referral processes with no overlap but now it is a lot more flexible. All the local services have been able to get to know and understand each other. Within this the neighbourliness in the area was fab. Neighbours checked in on each other and then contacted us in the charity sector if they needed support. Normally we get contacted by professionals and some self-referrals but neighbours really filled in that gap for hardly reached groups. We hope that this will continue rather than just being something that occurred in a crisis.

“Instead of asking standard questions or following a script we explored things through conversation, a bit like in detective work.”

Is there anything that others could have done to help you to provide ongoing support?

It was difficult being in the charity sector as, despite providing a statutory-funded service, often we did not quite know where we fit. Throughout lockdown there were regular changes in terms of the government guidelines,



What did you learn that will further improve the lives of people living with multiple conditions?

For us the biggest issue is still around digital access so our senior management team are looking out for funding for additional projects to get tablets in stock as this is one of the things needed.

As a team we've also had to really develop our skills in supporting people over the phone. We've developed this and learnt from our mistakes in the first phase of the pandemic and got processes in place. We think this is really important as we found that the right phone call made a difference. Even if people did not need practical support it really mattered to them that we had made the time to give them a call.

Really, though, what has become even more apparent during the pandemic is the importance of considering someone's social circumstances alongside their health issues. We know the NHS is trying to move towards a way of working that recognises the importance of the social determinants of health alongside the medical but we see that many healthcare professionals do not understand how the social sector works. Because of this they can struggle to take quick action for individuals that would improve their health and wellbeing – whether through signposting to organisations in the community or making referrals to other public services. However, the pandemic has given us the opportunity to work closer together so there is more clarity, and we hope this will continue.

Spotlight on inequalities

The London Borough of Southwark is one of the most diverse areas in the country with large BAME communities. It is ranked 41st most deprived out of 326 local authority areas.

The social prescribing team do not have anything specifically directed at the BAME or economically disadvantaged communities, but the support people are linked into is personalised and they work closely with organisations within BAME communities. Beyond this the team are always looking at how to reach individuals in Southwark's diverse communities, which is part of the driver behind the development of the new community hub approach. One thing that they are already doing, with their hot meal delivery project in partnership with Bermondsey Kitchen is to make sure that the menus are culturally appropriate so there is an Asian option, a Caribbean option and a British option.

As an organisation Age UK Southwark and Lewisham is training its managers in unconscious bias as well as offering equality and diversity training to all staff. Syeda would love to see befriending groups for older non-English speakers. Many existing groups do have interpreters that people can bring along, but these are expensive so only usually available for the first session which makes group discussions after that difficult.

One man's story

To understand how people have been affected we heard from one of Age UK Southwark and Lewisham's clients who had been referred to the team by their GP surgery for social prescribing to reduce social isolation.

Mr Adebayo* lives alone, is in his late 50s and recovering from a stroke. Being housebound and in a poor financial situation caused a significant deterioration in his mental health, to a point where he was having suicidal thoughts. However through the local partnership, Age UK were able to ensure he got the support he needed. This included an expanded social care package from the council, a referral for physio, delivery of a wheelchair and a pendant alarm that could be used without a landline as there is no phone. The team arranged for Dial-a-ride to take Mr Adebayo to local groups run by Southwark Disablement Association (SDA) when COVID-19 restrictions allow. SDA also provided

Mr Adebayo with a laptop for him to join online groups and Age UK are working to try and improve his wi-fi signal. Mr Adebayo is now in a much better position. "I would like to thank Age UK for making me more independent and helping me access my local community," he said.

**not his real name*



Yorkshire

In Yorkshire a new approach to reduce the risks from multiple medications identifies people with multiple conditions and frailty for medication reviews by pharmacists. Recommendations are made to GP practices about which medications can be stopped, along with resources, training and tools from the Yorkshire and Humber Academic Health Science Network (AHSN). A successful pilot of this approach in Harrogate was detailed as a [case study](#) in the 2019 Multiple Conditions Guidebook.

In Autumn 2020 we spoke to Yorkshire and Humber AHSN's Clinical Advisor, Caroline Dixon, to find what had been learnt from the follow-up project, ending in March 2020, to rollout the approach across the South Yorkshire and Bassetlaw Integrated Care System. Whilst this is pre-pandemic it is interesting to see how relevant some of their learning has proven to be.



Can you remind us about the approach taken to reducing multiple medications and the scale of the new project?

To start, a particular cohort of people is identified. In the case of South Yorkshire and Bassetlaw it was people with multiple conditions and frailty, but it could be others, for example people with learning difficulties, or on a particular group of medications. Identified individuals are invited for a medication review with a pharmacist and the findings are then reported back to their GP to implement. However this is not as straightforward as it sounds so the pharmacists and GPs are given training and new tools to support the process along the way. In Harrogate we piloted the approach with 12 GP practices. For the rollout project across South Yorkshire and Bassetlaw, nearly 200 practices were involved across five clinical commissioning groups.



What support, training and tools did you provide?

In the pilot project we worked with individual GP practices and held small group workshops on different topics. Given the scale of the new project we instead ran one large workshop for GP practices and focused our training capacity on the practice pharmacists. Our aim was not only to upskill them in the latest technical knowledge about deprescribing but also to give them the confidence and tools to act as the lead professional and cascade knowledge themselves in primary care. Practice pharmacists have an important role to play but often do not get practical training about how to explain their expert recommendations about how to reduce polypharmacy, the clinical term used to describe the prescribing of multiple medications, to GPs and other healthcare professionals. This can be difficult to get right. We provided training but it was the chance to practise and role play different scenarios that really made the difference.

We also noticed a difference in uptake of the project across South Yorkshire and Bassetlaw. We are currently working to try and understand what encouraged participation in some areas and how we can use this learning to help encourage a change in practice at scale.

Are there things you would do differently next time?

One thing that we did not really pick up on from the pilot was the length of time needed to go through the process from start to finish. In some cases, for example, new drugs are recommended to replace multiple other medications or it can take a while to see the effects. In these instances rather than the 2-4 months we would recommend allowing 6-8 months to complete the process.

What do you think the implications are for this approach given COVID?

Medication reviews should be done regularly by GP practices, but it is time consuming and with everything being behind because of COVID-19 it could easily be seen as a luxury or less urgent. But in terms of multiple conditions, regular medication reviews are key to ensuring people have the best quality of life they possibly can. And reducing unnecessary polypharmacy is really the holy grail of a project in health. It improves quality of life for individuals whilst also directly reducing costs for the NHS. For this reason we think it really should remain as a priority.

Luckily for us, at its core is the use of digital technology so in many ways COVID-19 should not affect this approach for medication reviews. Thinking more generally, and about the eight ingredients identified in the original Guidebook, especially the focus on mental health, COVID-19 probably makes them even more important for people with multiple conditions. But they are also undoubtedly harder to achieve. For example, we used to have a patient focus group that met but this now cannot happen. It is also harder for peers to get together. And whilst online video platforms and other technology is helpful, it can be difficult to make things happen on Zoom, particularly with the elderly.

What does the future hold?

At the moment, with everything going on we are currently reviewing the strategic priorities of the Yorkshire and Humber AHSN. There are other Integrated Care Systems in the region that are potentially interested in this new approach to reducing polypharmacy. We continue to work with partners to determine next steps but very much hope that others can learn from our work.



In the pilot phase, because of the frail condition of many of the individuals involved, the pharmacist would often have to go to their house to conduct the review. But people would not always answer the door so it was recommended that the rollout use digital technology, with help upfront from a carer or other individual to set it up. What we did not know at that time was how much more normal this way of working would become.

Is there anything that could increase the impact even more?

There has been an issue in recent years, and even more so now with the COVID-19 restrictions, with low take-up of medication reviews offered by GP practices. The date of an annual medication review is normally written on repeat prescriptions but increasingly people order their repeat prescriptions online. Whilst these electronic prescriptions are a good thing, and have been incredibly helpful during 2020, they do mean that annual reviews can easily get missed. Community pharmacists have an important role in this, but with COVID-19 and increased use of delivery drivers people are not physically coming into pharmacies as much. Obviously some people with multiple conditions are very engaged and on top of what they need to do and when, but for others it is less easy. Campaigns like [Me and My Medicines](#) are helpful but there is probably more that we could do to increase public awareness, on social media for example.