ROYAL COLLEGE OF GENERAL PRACTITIONERS

	COUNCIL 26 February 2016 Responding to the needs of patients with multi-morbidity: A vision for general practice	REF: C /xxx	ITEM xx

CATEGORY

For

DISCUSSION

SCOPE

UK Wide

LEAD OFFICER(S)

Chair of UK Council, Prof Maureen Baker

LEAD DIRECTOR

Paul Rees, Executive Director, Policy and Engagement

EXECUTIVE SUMMARY

The provision of effective, person centred care to patients with multi-morbidity is key part of creating a modern 21st century NHS and is a challenge in which general practice is very much at the forefront. This was reflected last year, when Council adopted the development of measures to incentivise the provision of patient-centred care to those living with multi-morbidity as one of its policy and campaigns priorities for 2015/16.

While the College has previously undertaken work on multi-morbidity, a need has been identified to set out the College's position on this topic in the form of an authoritative College policy statement. This paper presents a preliminary version of such a statement.

The draft covers the experience of patients with multi-morbidity, the barriers that currently exist to improving their care and the action that needs to be taken in order to overcome these. The paper has been put together over a short timescale and it is recognised that there are some areas in which it will require further development. Its contents have been informed by the input of an expert advisory group, the members of which are: Tony Avery, Margaret Cupples, Adrian Edwards, Trisha Greenhalgh, Jane Fenton-May, Bruce Guthrie, John O'Kelly, Stewart Mercer, David Oliver, Rupert Payne, Robina Shah, Chris Salisbury and Clare Taylor.

PATIENT INVOLVEMENT / IMPLICATIONS

The number of patients with multiple long-term conditions is growing and meeting their needs is a key test for the NHS. The Chair of the College's Patient and Carers Partnership Group was a member of the working group that advised on the development of the paper, and as a member of Council, will have an opportunity to contribution to Council's discussion.

CONSULTATION WITH SCOTLAND, WALES AND NORTHERN IRELAND

The Devolved Council Chairs nominated representatives onto the working group that has been advising on the development of the paper. All of the Devolved Council Chairs and their staff teams have been given the opportunity to input into and comment on the paper, although due to the constrained timescale in which the paper has been written, some have not been able to do so.

	RESOURCE & COST IMPLICATIONS Work in this area will be taken forward by the Chair of Council and the Policy and Campaigns Team out of existing resources. **PROGRAMME BOARD WORKSTREAM** Policy and Campaigns
AUTHOR(S) : Holly Jeffers	**RECOMMENDATION(S)** 1. **That Council debates the draft policy statement on multi-morbidity**

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Responding to the needs of patients with multi-morbidity: A vision for general practice

Introduction

Multi-morbidity is a major issue facing modern day general practice. Analysis conducted by the College has shown that by the year 2025 the number of people living with one or more serious long-term condition in the UK will increase by nearly one million, rising from 8.2 million to 9.1 million. Combined with the current ageing population, the increased prevalence of long-term conditions is having significant impact on health and social care, and could cost general practice an extra £1.2 billion a year over the next decade.

While recognition of the challenges posed by multi-morbidity is gradually growing, there is still a long way to go in ensuring that the health system responses adequately to the needs of this important patient group. This paper examines the experience of patients with multi-morbidity, the barriers that currently exist to improving their care, and the action that needs to be taken by practitioners and policy makers in order to tackle these.

The multi-morbidity challenge

Defining multi-morbidity

Multi-morbidity is often defined as two or more long-term conditions in the same individual.

Unlike co-morbidity, which describes two or more conditions which are related, multi-morbidity refers to two or more conditions which coexist independently. In addition, whilst with co-morbidity the focus is on an index condition (e.g. diabetes); multi-morbidity does not imply any one condition is more important than another. This is particularly relevant in the general practice setting, as the relative importance of different conditions can wax and wane over time.

When defining multi-morbidity, it is also important to remember that multi-morbidity itself is not a disease. Every patient's experience of multi-morbidity is unique. To each patient, different things matter and this makes establishing the impacts of multi-morbidity, both on the patient and the wider health care system, difficult to measure.

Who and how many people are affected?

Estimates of the proportion of the population with multi-morbidity vary, according to the datasets used and how many different conditions these include. A systematic review of multi-morbidity research showed that eligible conditions which could contribute towards defining multi-morbidity, vary between 5 and 335 conditions[1], with other studies suggesting this could be in excess of 10,000[2]. A retrospective study by Salisbury *et al.* (2011) of approximately 100,000 patients across 182 practices in England found that when the Adjusted Clinical Group list of conditions are employed 58% of patients had multi-morbidity[3]. Using the more limited list of conditions included in the Quality and Outcomes Framework, this fell to 16%. In Scotland, Barnett *et al*. (2012) extracted data on 40 morbidities from a database of approximately 1.75 million people and found that 23.2% of the population studied had multi-morbidity[4].

Despite the variation in definitions used what is clear is that the prevalence of multi-morbidity across the UK is rising. Analysis conducted by the College has shown that by the year 2025 the number of people living with one or more serious long-term condition in the UK will increase by nearly one million, rising from 8.2 million to 9.1 million.

Research indicates that the likelihood of developing multi-morbidity is linked to the following factors:

- Age. Salisbury *et al.* (2011) found a positive correlation between age and both the percentage of people living with multi-morbidity and the number of conditions experienced[5]. See Figure 1.

- Deprivation. Evidence suggests that multi-morbidity occurs in people 10-15 years earlier in most deprived areas than more affluent ones[6].

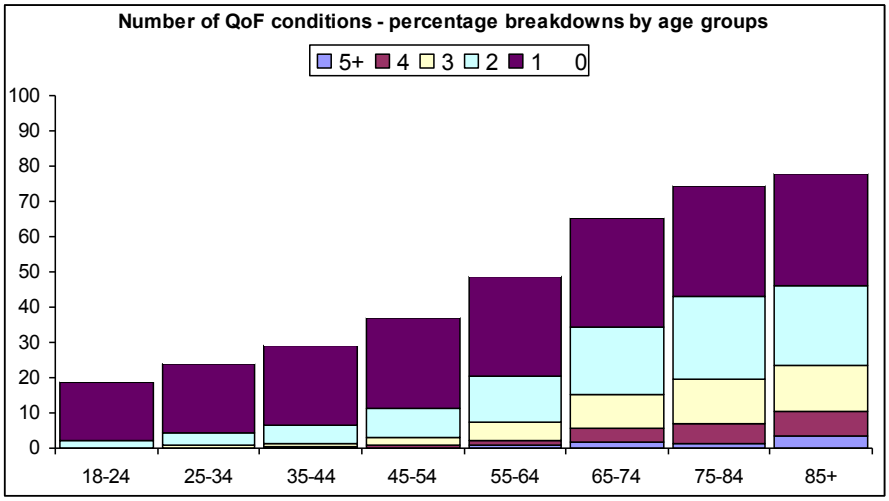

Figure 1: Number of QOF conditions – percentage breakdowns by age group (Salisbury *et al.* 2011)

While older people are more likely to experience multi-morbidity, it is however important to note that it is not just a problem amongst the elderly. For example, Barnett *et al.* (2012) found that of the 1.8 million people examined in their study there were more multi-morbid individuals aged below 65 than above[7].

How effectively does the current health system serve patients with multi-morbidity?

As more people live longer, patients with multi-morbidity are accounting for an increasing proportion of the activity in the health care system.

The Department of Health has estimated that in England long-term conditions account for 50% of all GP appointments, 64% of outpatient appointments and 70% of inpatient bed days[8]. Research by Akker and Muth[9] suggests that the proportion of general practice appointments accounted for by patients with multi-morbidity could be even higher at 80%.

Overall, £7 out of every £10[10] in the total health and social care expenditure in England is spent on patients with multiple long-term conditions, with the spend per patient per year increasing according to the number of long-term conditions they have.

Despite this patients with multi-morbidity often have a worse experience of the health care system. They often are unable to access health care services where and when they are most needed, suffer from a lack of consultation time and receive fragmented care resulting from a disjointed approach across different specialisms.

They are also more likely to have unplanned admissions to hospital. Studies have demonstrated that up to 96% of patients in western counties who are admitted from A&E are multi-morbid compared to 22-65% of all hospitalised patients[11].

In addition to these challenges, multi-morbid patients have to manage the burden of their illnesses and treatments. The implications of this can vary greatly between different patients and encompasses the physical, psychological and societal impact of their illnesses. Patients often have to live with the complications that the combination of physical and mental health conditions can bring, and where frailty and disability occur alongside multi-morbidity, these issues are exacerbated further.

Continuity

Patients who receive continuity of care in general practice have better health outcomes, higher satisfaction rates and the healthcare they receive is more cost effective[12]. In particular relational continuity, defined as the extent to which a patient experiences an ongoing relationship with a clinician, is essential for patients with multi-morbidity who will typically have numerous interactions with the healthcare system over time.

However, despite being those can benefit most from continuity; patients with multi-morbidity are often those who don't receive it[13]. New services and roles are frequently structured around individual conditions for instance GPs with a special interest and disease specific clinics. However, these are not necessarily geared towards delivering a better quality of care or improved experience for patients with multi-morbidity. Specialist care also risks exposing these patients to greater discontinuity. Patients experience fragmented care, attending multiple appointments with different healthcare professionals; having numerous, sometimes duplicated, tests conducted; and having to make sense of conflicting advice from different doctors.

Burden of medication

Patients with multi-morbidity are often prescribed a vast amount of medication in an attempt to manage their conditions. Whilst medications are intended to improve a patient's health outcome, they can become a burden and affect a patient's quality of life. Evidence of this can be seen in 1/5 of preventable hospital admissions that are due to patients not adhering to their medication[14].

Polypills, combining multiple medications into one pill, could offer a way of reducing the number of tablets a patient with concordant conditions takes. However, as polypills are still in their early stages, more monitoring and evaluation of their costs and benefits, including impacts on patient adherence and reduction of treatment burden, is needed.

A broader view also needs to be developed as to what is included when making judgements about drug effectiveness. Whilst trials may show a drug to be successful, in patients with multi-morbidity there are more factors at play, such as cognitive and functional impairment, and the quality of a patient's social support network. Particular recognition needs to be given to the need for older patients to have support to manage their medication, and the need for both health and social care services to collaborate in ensuring that appropriate support plans are in place.

Common clusters of conditions

Patients with multi-morbidity have to live with the complex interactions of their conditions. There are, however, sets of conditions that are more common than others. Despite there being these common combinations there is little understanding of the impact these conditions have on each other.

In order to make progress in delivering quality healthcare to patients with multiple long-term conditions, it makes sense to focus on further study of condition combinations that are most common. Common clusters across the world have been reported to be cardiovascular/metabolic, anxiety/ depression/psychological disease, and neuropsychiatric or psychogeriatric conditions[15]. A systematic review by Violan *et al.* 2014 also investigated patterns of multi-morbidity and identified the most common pair of conditions as being osteoarthritis plus a cardio-metabolic condition, such as diabetes or hypertension[16].

Figure 2 illustrates clusters of common conditions as reported in the study by Barnett *et al.* (2012)[17]. A secondary analysis of the same study found that only 10 conditions accounted for the 5 most prevalent conditions at different ages in patients with multi-morbidity across the life-course; in every ten-year age group pain and depression featured in the top 5 conditions (Mclean *et al.* 2014)[18]

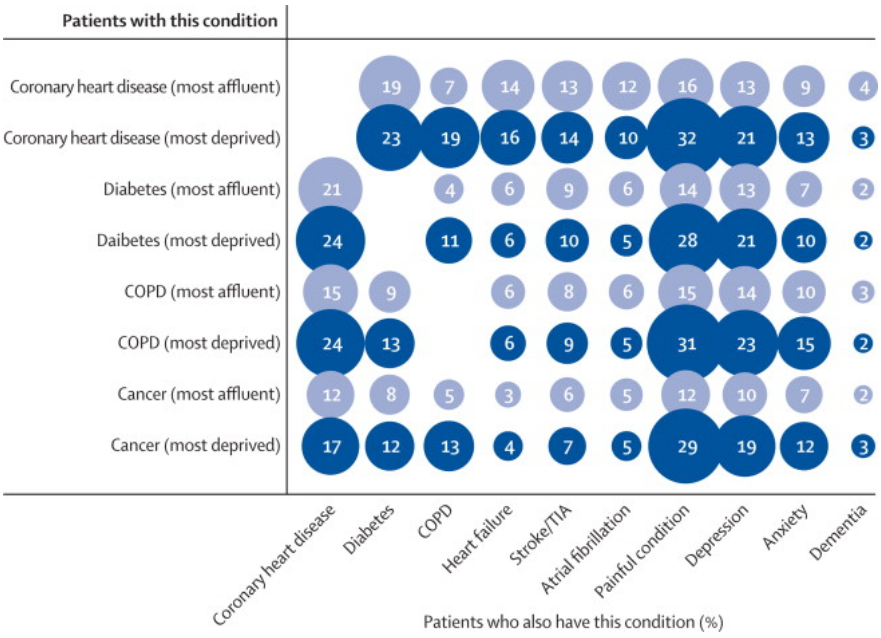

Figure 2: Selected comorbidities in people with four common, important disorders in the most affluent and most deprived deciles (Barnett *et al.* 2012)

What barriers do GPs face in providing care to people with multi-morbidity?

General practice is facing unprecedented challenges. There is currently a lack of funding, a lack of GPs, and little time for GPs to adapt and innovate. In addition, patients with multi-morbidities require more frequent, longer consultations, and those in general practice must meet the needs of these patients, despite the paucity of research and guidelines to do so.

Lack of time

Current consultation lengths stretch doctors' abilities to deliver quality patient care for patients with one short term bout of illness, let alone those with multiple long-term complex conditions.

In England, in 2006, the average consultation length was 11.9 minutes[19], already longer than the standard 10 minute slot, showing that GPs desperately need more time to treat their patients. Research undertaken in England into the context of GP consultations has estimated that in each consultation, on average, 2.5 different issues are discussed[20]. With many multi-morbid patients having in excess of 5 conditions, the current system makes it difficult for those in general practice to care for patients who have chronic conditions and only 8% of UK GPs feel that the current consultation length is long enough[21]. Whilst there is a lack of research into the feasibility of offering extended consultations as standard to all multi-morbid patients, it seems apparent that these patients will need longer consultations to make their care most effective.

Research into multi-morbidity

Multi-morbidity is one of the greatest challenges in 21st century healthcare. Despite this, research into patients with multiple long-term conditions, whether these be physical or mental, is still very much in its early stages.

Patients with multiple long-term conditions are often excluded from single disease clinical research, in order to ensure there are no influencing external factors. This method of research aims to understand how to treat an 'average patient'. As a result there is little evidence base for patients with multiple long-term conditions, yet it is often patients with multi-morbidities to whom the findings of this research are applied.

Whilst there has been slightly more research into co-morbidity, it is often specialist based and the findings are not always applicable to patients with multi-morbidities in the primary care setting. A systematic review of US based studies published between 2008 and 2014 showed that only twenty-seven met the selection criteria of including those with multiple long-term conditions; addressing either improved clinical outcomes, efficiency of health care and spending or patient satisfaction and making comparisons to a baseline measurement[22].

In addition to this, where research is conducted it is often led by those with vested interests in the study outcomes. The drug and medical services industry plays a large role in clinical trials, and is often responsible for defining an illness and the levels of benefit at which a drug is deemed to be successful[23]. This makes it difficult for clinicians to establish if an intervention is suitable for an average patient, let alone for patients with multi-morbidity.

More broadly there is a lack of research into the ways in which professional practice can be developed and services designed to provide the most effective care to patients with multi-

morbidity. It is fundamental that more research is conducted into meeting the needs of patients with multiple long-term conditions, alongside influencing factors such as socio-economic deprivation, condition severity, frailty and vulnerability[24]. In addition better understanding is required of how clinicians and patients use research evidence, and how this feeds into clinical communication, diagnostic options and shared decision making[25].

Polypharmacy

Whilst patients may struggle to manage the numerous medicines prescribed for their multiple conditions, GPs also face challenges in prioritising medicines of patients with multi-morbidities.

Current guidelines advise GPs on medicines to prescribe in order to treat a particular condition - not how to treat the patient, in the context of all their conditions. This can often result in GPs being advised to prescribe numerous different medications. Sometimes polypharmacy is appropriate, with patients experiencing significant benefit from being on multiple medications; however, often it is problematic[26]. One study by Wallace *et al.* (2015) reported that approximately 20% of patients with two conditions were prescribed four to nine drugs, and 1% of patients were prescribed 10 or more drugs. For patients with at least 6 long-term conditions this increased to 48% and 42% respectively[27]. Additional research into age and multi-morbidity, reported that around two thirds of patients over the age of 70 take 5 or more medicines, with one third of this group taking 9 or more drugs a day[28].

Furthermore, while GPs are expert generalists, it is extremely difficult to know how drugs recommended for the considerable number of combinations of single disease conditions will interact. The more drugs a person is prescribed, the greater the risk of human error and of adverse drug reactions. The implications of this are far reaching. Adverse drug reactions accounting for 6.5% of hospitalisations, half of which are preventable[29]. In addition there is a significant financial implication with medicines currently costing the NHS more than £10 billion a year[30].

Limitations of guidelines when treating patients with multi-morbidity

Single disease guidelines offer limited assistance and can even be contradictory when providing care to patients with multi-morbidity. NICE's current single disease focused guidelines do acknowledge that comorbidities should be considered when developing a management plan[31]; however, little reference is made to multi-morbidities. As a result GPs face information overload from numerous conditions guidelines; a lack of clinical evidence on effectiveness of interventions for multi-morbid patients; and barely any evidence into most cost effective treatments.

NICE is currently in the process of developing a guideline to assist the care of patients with multi-morbidity. Rather than attempting to create recommendations for every single possible combination of conditions, it is expected that the scope focuses more on broad principles including identifying which people with multi-morbidity most need an approach to care which goes beyond single disease guidelines and a focus on meeting their varying priorities, preferences and needs. However, their ability to cover the full range of circumstances that clinicians may encounter will inevitability be limited and if they are to be successful they will need to be complemented by measures to enhance the ability of GPs to exercise professional judgement, manage uncertainty and enable shared decision making.

Physical and mental multi-morbidities

The combination of long-term physical and mental health conditions is very common. The King's Fund has reported that 30% of people with a long-term condition also have a mental health condition and 46% of people with a mental health problem have a long-term illness[32]. Despite this there are few studies that review the effects of physical and mental health morbidity on each other.

The interaction of long-term physical conditions and long-term mental health conditions poses particular challenges for the health care system. Whilst a patient may develop depression as a result of living with a long-term physical illness, depression itself can reduce a patient's ability to manage a physical condition. Research has demonstrated that 23% of patients with one chronic condition reported depression, compared to 40% of those with five or more conditions[33]. The association between mental and physical health problems is also socially patterned, with patients living in deprived areas having a much higher prevalence of mental health problems for a given number of physical health conditions (Barnett *et al.* 2017, to be published)

In addition, the ageing population means more people are living with dementia. Dementia can make management of a physical condition especially challenging due to forgetfulness or confusion, and if medication is not taken a patient's physical condition may decline. Smoking is also most common in patients with mental health conditions, with Public Health England reporting that 64% of patients with mental health conditions were also addicted to tobacco[34].

Stigma around mental health issues is also a challenge when managing multi-morbidity. Patients with physical conditions may choose not to disclosure their mental health conditions, which can make treating their illnesses difficult for a GP. For example, at times it can be difficult for a GP to differentiate the signs of depression and signs of ageing[35].

The effect of mental on physical illness is estimated to cost the NHS £8 - £13 billion a year in England[36]. It is therefore paramount that mental health be recognised as being of equal importance to physical health when treating multi-morbidity. Research by Coventry *et al.* (2015)[37] demonstrates where depression and a long-term physical condition were treated collaboratively; rates of depression were 0.23 SCL –D13 points lower than when they were treated separately.

Incentives which treat illnesses, not patients

Contractual mechanisms such as the quality and outcomes framework have not historically tended to incentivise a holistic approach to treating patients with multiple morbidities, focusing instead on single diseases. The Quality and Outcomes Framework (QOF) is part of the General Medical Services Contract, and rewards practices for treating individual long-term illness, for example asthma or diabetes. However, this framework makes no attempts to review, and reward, how well practices treat patients with multiple long-term conditions.

Under QOF large numbers of patients with multi-morbidity are excluded, with individuals with 'high dependency and long-term conditions' accounting for 11.2% of exemptions in England and patients with 'mental health and neurology' accounting for 14.5%[38]. While this at least avoids penalising practices for tailoring their approach to meet the needs of patients with multi-morbidity it also skews care and attention away from them.

Despite the intention of QOF being to reward practices for the quality of care, there is still need for a reward system to develop that takes into account the needs of patients. There is evidence to suggest that non-disease related outcomes may provide more accurate indication of care quality. For example, relationship quality, self-management and consistency, have been reported to predict mortality more accurately than measures of disease progression[39]. This implies that focusing purely on disease related outcomes may not be the best way to treat, or measure the quality of care, patients with multi-morbidity receive.

Interventions to improve outcomes for people with multi-morbidity

The increasing number of patients living with multi-morbidity is a profound challenge for the NHS, and it is essential that measures are taken which harness the potential of general practice to improve the outcomes for these patients. These interventions will entail both patient centred changes and organisational changes at a GP practice level and national level.

- **GP practice level**

Consultation length

A longer consultation length for patients with multiple long-term conditions is an approach that would enable these patients to have more time to discuss their complex conditions.

A study by Mercer *et al.* (2007) in Scotland found that patients in the most deprived areas had more problems to discuss (especially psychosocial), yet clinical encounter length was generally shorter – at 8.2 minutes on average compared to 8.6 minutes in more affluent areas[40]. Further research in Scotland that looked into the impact of longer consultations in deprived areas found that an increase in consultation length for patients with complex needs to an average of 15 minutes was associated with enhanced levels of patient enablement[41]. The study recommends that 15 minute consultations should be standard for patients with multi-morbidity, and suggests that more integrated working would free up time to allow this to happen[42].

The Deep End Project in Glasgow has taken these insights and helped to apply these by supporting practices to explore a range of approaches to increase face to face clinical time with patients in deprived areas including offering longer consultations[43].

Electronic Health Record

To provide high quality care to patients with multi-morbidity it is essential that those treating them have access to comprehensive medical records. Hospitals, GP out of hours services, emergency services, GP practices and clinicians conducting home visits all need to be able to share information in a timely fashion on aspects of care such as repeat medication, acute medication, laboratory results and discharge and outpatient letters. This is becoming even more important as multidisciplinary teams become more common in 21st century care.

Furthermore, electronic health record systems have the potential to develop and shape new ways of clinical working. Advanced health record systems could search for previous changes in medication, alert doctors to potential adverse medical interactions and also calculate risks

versus benefits for certain patient interventions[44]. In England, the 3D project has involved developing a sophisticated interactive computer template for patients with multi-morbidity, removing the need to use a series of individual disease focused templates for these patients and steering clinicians to focus on patient's individual needs. In Northern Ireland, the Health and Social Care Board is developing IT systems for risk stratification that will interrogate patient records and identify patients with multi-morbidities, polypharmacy and their statistics on hospital admissions.

Collaborative care and support planning

Collaborative care planning is widely recognised as being crucial to ensuring that patients with multi-morbidity receive quality healthcare, with this approach being recommended by the National Institute of Health and Clinical Excellence. Key components of this approach include:

- Shared decision making between patients and clinicians
- Proactive goal setting that reflects what is most important to the patient
- Use of multidisciplinary teams that draw on the expertise of a range of professionals as part of a coordinated approach
- Longer consultations
- Continuity of care with a named professional

In Scotland, a 5 year programme of research (2009-2014) called 'Living Well with Multi-morbidity' resulted the development of a whole-system intervention (CARE Plus) for patients with multi-morbidity in very deprived areas. This involved substantially longer consultations for targeted multi-morbid patients, relational continuity with their GP, a structured care plan based on the patients own goals, and support and training for the GPs[45]. A feasibility cluster RCT in Glasgow showed preliminary evidence of benefit in terms of quality of life and cost-effectiveness (Mercer, 2016, personal communication)

The 3D study[46] is another example of how providing holistic care may successfully improve the health outcomes of those with multiple long-term conditions. The research assesses the 3 Dimensions of health, Drugs and Depression, the issues of illness burden, treatment burden and lack of patient centred care. Interventions conducted to produce better health care outcomes of patients with multi-morbidity were:

- Identification and prioritisation of patients with multi-morbidity
- Improving continuity by having a named GP
- Longer consultation times
- Person centred assessments every 6 months, as opposed to reviewing conditions on an individual basis
- Integration with a physician who was available to provide over the phone advice and co-ordinate hospital care.

- **National level**

Commissioning for patients with complex health needs

The current system of designing care pathways around single diseases simply does not work for multi-morbid patients. When commissioning care, more emphasis needs to be placed on the fact that a large proportion of patients now have multiple long-term conditions, and this will continue to rise in years to come. Future systems of commissioning healthcare should support the integration of services, acknowledging that current budgets are fragmented, in order to meet the needs of patients. One means of doing this being rolled out in England, is through primary care co-commissioning.

Education and Training

In addition to recruiting more doctors and nurses to general practice, those in training need to gain more experience of caring for patients with multi-morbidity. Education needs to move away from the current approach of focusing on single diseases and move towards holistic care. Training should ensure health care professionals recognise that the needs of the patient are the priority and not the illness itself, alongside ensuring that the patient is involved in making shared decisions which enable them to self-manage.

National bodies responsible for education across the UK, have an important role to play in reviewing existing curricula for the training of professionals who will be caring for those with multi-morbidity and making changes where necessary. In particular the RCGP has argued for an extension in the length of postgraduate training from three to four years in order to allow more time to ensure that GPs are equip with the knowledge that they need to effectively care for patients with multi-morbidity.

Improved information and decision making tools

More sophisticated information and guidance needs to be developed to ensure patients with multi-morbidity receive adequate care. This needs to be clearer on the benefits and risk of interventions for patients with numerous conditions, and be accompanied by decision-making tools that enable the doctor and patient to tailor their care to the individual's preferences.

The introduction of the forthcoming NICE guidance will provide clinicians with a broad set of overarching principles for treating patients with multi-morbidity. It may also be possible to develop more detailed guidelines that address some of the most common combinations of disease, or synthesize relevant advice based around presenting symptoms in a similar fashion to NICE's recent cancer guidelines. However, realistically there will never be a guideline that is tailored to every patient and set of circumstances.

Technological developments could support doctors when prescribing multiple medications by highlighting potential risks[47]. Online systems recording numbers to treat, for example, or duration for which medication should to be taken, could ensure that patients have the greatest chance of positive health outcomes.

Resourcing implications

In order to provide quality care for the increasing number of patients living with multiple long-term conditions, more needs to be done to address the resourcing implications for general practice. General practice is currently facing a lack of GPs, with the College currently calling for 10,000 more GPs to be recruited across the whole of the UK and these GPs are desperately needed to provide care for patients with more complex needs.

It needs to be recognised that in addition to being more clinically effective providing better care for patients with multi-morbidities is at the same time more cost effective in the long-term to the NHS. This needs to be reflected in decision making frameworks for resource allocation within the NHS.

Recommendations

- Recognise the importance of generalism in providing care for patients with multi-morbidity.

- Prioritise longer consultations for those with multi-morbidity, allowing patients to form on-going relationships with those providing their care in general practice.

- Greater collaboration between general practice and specialists, aiming for coordinated, holistic care, especially in regard to polypharmacy.

- Face to face dedicated medicine reviews for all patients with multi-morbidity - ideally incorporating the skills of practice based pharmacists.

- Equip GPs to care specifically for patients with multiple long-term conditions and improve them with tools to enable them to make informed decisions for this group.

- Reconsider performance related payments which relate to disease specific targets and develop new financial mechanism to help embed the provision of whole person care, e.g. by incentivising longer consultations for patients with multi-morbidity.

- Consider the inverse care law when tackling multi-morbidity and ensure that the NHS channels funding to areas that most need services for those with multi-morbidity, not only to areas of greatest population size.

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