Appendix 1

Self-management of long-term Conditions – a briefing

1 At the stakeholder event held in July 2011, it was agreed that the second review priority on the current work programme would be self-management of long-term conditions. Around 15 million people in England have one or more long-term condition. This figure is predicted to rise by a third over the next ten years. People with long-term conditions are the most frequent users of health services, accounting for 50% of all GP appointments and 70% of all inpatient bed days (this often being linked to concerns over revolving-door/frequent admissions). Treatment and care of this group accounts for 70% of the primary and acute care budget. Around 70-80% of all people with long-term conditions can be supported to manage their own condition. A recent study in The Lancet suggest that the health system in the UK cannot cope with the rising number of over-65s with long-term medical conditions and needs radical change with improved co-ordination and a more personalised approach.

2 Long-term conditions include arthritis, cancer, cardiovascular disease, HIV/AIDS, asthma, diabetes, incontinence, sensory impairment, COPD (chronic obstructive pulmonary disease), epilepsy and certain mental health conditions. Management of long-term conditions in the community has figured in many of the presentations made as part of the Closer to Home Strategy monitoring group activities as they have visited Localities e.g. respiratory services and STINT.

3 Self-management is important, because such patients are more likely to;

- Experience better care and well-being
- Reduce the perceived severity of their symptoms, including pain
- Improve medicines compliance
- Prevent the need for emergency and health services
- Prevent unnecessary hospital admissions
- Have better planned and co-ordinated care
- Remain in their own home
- Have greater confidence and a sense of control
- Have better mental health and less depression.

4 The DoH report ‘Self Care – A Real Choice’ (2005) suggests that early investment in local strategies could reduce:

- Visits to GPs by 40%
- Visits to out-patients by up to 17%
- Visits to A/E units by up to 50%
- Drug expenditure.

5 Today’s fact-finding exercise has been arranged to help agree a focus and scope for this work. Members of the task and finish group will recognise that, at present, this is a broad theme affecting a large proportion of the population with significant resources involved. Members may therefore wish to take a view
about focusing on specific conditions rather than attempting to look at all areas affected. To this end, and following further consultation with NS colleagues about their priorities and concerns, specific information is being provided to day about diabetes care.

6 Diabetes is a growing national problem. The percentage of the population diagnosed with diabetes more than doubled between 1994 and 2009. Numbers are expected to increase from around 3.1 million in 2010 to 3.8m by 2020. National clinical audit indicated that only half of those diagnosed received all recommended care processes that could reduce the risk of developing diabetes-related complications. Less than 1 in 5 people with diabetes are achieving recommended treatment standards that reduce risk of complications. There are significant variations in care across the country with the best PCT delivering only 69% of nine basic care standards identified and the worst just 6%. While costs are put at £1.3bn in 2009-10, poor data quality significantly underestimates the true costs which the National Audit Office (NAO) puts at £3.9bn (but see different figures/estimates below). NAO suggest that present arrangements do not deliver value for money and that better understanding/management could save the NHS £170m a year. A recent report in Diabetes Medicine suggested that the majority of current spending on diabetes was avoidable with 80% of a £9.8bn budget going on the cost of treating complications. More alarmingly, the York Health Economics Consortium suggests that the increase in diabetes sufferers could cost the NHS £16.9 billion and threatens to bankrupt the service and put the future of free healthcare in jeopardy.

7 In Cumbria there are over 20,000 people with diabetes and this figure is predicted to rise by two thirds over the next 15 years. It is believed that around 5,000 people in the county have this condition but are undiagnosed. Prevention is key and the national DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme was introduced locally in 2009. This course is designed to help people newly diagnosed with type 2 diabetes to better understand their condition and to provide advice. More recently a new educational course called ‘Walking away from diabetes’ has been introduced aimed at helping those at risk of developing type 2 diabetes. The impact/success of such initiatives should form a key part of any enquiry into diabetes care.

8 It is suggested that an examination of long-term conditions could include:

- Incidence (national v. local comparisons) and views of key players e.g. GPs and other commissioners on unmet needs. Also a description of where they purchase services both from NHS and non-traditional providers (private and voluntary).
- A description of services currently available, utilisation and outcomes which identify what good looks like, capturing innovative and joined up approaches.
- A description of what is needed to better deliver self care in terms of staff training, networked arrangements and information and support (to both staff and patients).
• The patient perspective on choice, what is and is not working for them and why. A particular focus could be on the Expert Patients Programme and the experiences of local user groups.

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