| 12 January 2023 | ITEM: 8 |
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| **Health and Wellbeing Overview and Scrutiny Committee** | |
| **Self-Care in the Context of Living with Long Term Conditions – A Joint Strategic Needs Assessment** | |
| **Wards and communities affected:** All | **Key Decision:** Non-key |
| **Report of:** Emma Sanford, Strategic Lead for Healthcare Public Health | |
| **Accountable Assistant Director:** Sara Godward, Assistant Director of Public Health | |
| **Accountable Director:** Jo Broadbent, Director of Public Health | |
| **This report is** Public | |


**Executive Summary**

Increasing demand across the NHS and social care system in England, in both the number of patients and the associated cost of service delivery, can largely be attributed to: an ageing population; staffing issues; and a rising number of people with long-term condition (LTCs):

1) Around half of all GP appointments take place with patients with LTCs.
2) In the last five years, there were large increases in A&E attendances per day and even larger increases in emergency admissions. Patients with LTCs account for a large proportion of this activity, with a sizeable number having multiple conditions.
3) People with LTCs often struggle with daily activities. Social care provides a range of services supporting these activities. Nationally, the demand for social care support is increasing.

As a result of their use of services, the annual health and social care cost for a person with an LTC is three times higher than for a person without an LTC. This leads to 70% of the NHS budget being spent on patients with LTCs.

Self-care activities support improving the Quality of Life (QoL) and the health outcomes of those with LTCs, and thus could assist in reducing LTC associated demands and costs. However, they are not currently prioritised or sufficiently supported in the health care system.

This JSNA provides an evidence-based review of local services to support the development and expansion of the self-care provision in the Mid and South Essex ICS area, with a focus on three particular LTCs: Diabetes Mellitus (DM); Chronic Obstructive Pulmonary Disease (COPD); and, Heart Failure (HF).

Issues identified throughout this report are of multivalent, hence require action at different levels across the system: personal, local, regional and national level.

Six main themes were observed:

1) services that contribute to self-care across the STP are fragmented and irregular (largely due to a lack of strategic direction across the patch);
2) information is not readily available to patients, providers and commissioners (with issues due to lack of data collection and sharing);
3) patients and primary care providers lack the capacity and skills to make the most out of their interactions;
4) multimorbidity is increasing and needs to be addressed holistically;
5) the need for financial redistribution (with most of the funding going towards treatment in secondary care rather than prevention and support in the community);
6) self-care as a topic is in its infancy and evidence still needs to be developed.

To facilitate a coordinated effort to address these identified issues it is recommended that a joint strategy that aligns the prevention, early intervention and management agendas and addresses place-based barriers to self-care is developed at the ICS level.

Recommendations also focus on education and training of professionals. Upskilling programmes in *Making Every Contact Count*, patient activation, coaching and motivational interviewing all empower staff to hold the difficult conversations needed to engage patients in programmes that can support them.

At the neighbourhood level there is an opportunity to pool resources to offer education and specialist support to patients that have harder to manage conditions. Moreover, variation within the ICS Alliance areas and PCNs reflect struggles that some practices might have locally. Building on other's successes and sharing best practice between these local practices can support with reducing the variation currently seen.

Patients should also be supported and empowered to use varied tools to manage their health and make the most out of a meeting with a health professional. Patients and carers can and should share information and be encouraged to empower each other through face-to-face and online support groups.

## 1. Recommendation(s)

**1.1 That the Committee review the needs assessment and the recommendations contained within and provide comment.**

## 2. Introduction and Background

2.1 The National Health Service (NHS) is facing increasing demand and year-round pressures across all levels of care. Secondary care, and in particular

emergency care, is being badly affected with an evident increase in both the number of patients and the associated cost of treatment.

2.2 This increased demand is largely attributable to two factors: the ageing population and a rising number of people living with chronic conditions such as diabetes, cardiovascular disease, and depression. Furthermore, the complexity of individual cases is increasing, with an estimated 2.9 million people in England in 2018 having multiple conditions, also called multimorbidities.

2.3 As a result, current health policy and research now places greater emphasis on the need for healthcare to adopt the principles of self-care as routine practice. The NHS' 'Long Term Plan' highlights the priority for people to have more control over their own health and personalised care when they need it.

2.4 Supporting people to self-care is vital and should be a key activity in our health and social care systems. For patients with LTCs and multimorbidities, optimal outcomes and quality of life depend on engagement in effective self-care activities. However, self-care is often not prioritised to the same level as traditional medical interventions by professionals and the healthcare system. As a result, there is an apparent lack of emphasis on support and referral to services that can assist patients in maintaining or improving lifestyle behaviours or in self-managing their conditions.

2.5 This Joint Strategic Needs Assessment (JSNA) focuses on self-care. It aims to provide an evidence base for the development and improvement of the care and the ways in which we support and empower patients to self-manage LTCs and their general health. In line with the current NHS strategy and the Five Year Forward View, this assessment focuses on the Mid and South Essex Integrated Care System (ICS; formerly Sustainable Transformation Partnership / STP). This will allow for the report to influence system-wide priorities and contribute to the planning of more coordinated services.

2.6 As self-care practices span across numerous health and wellbeing domains, the assessment and recommendations of this paper are focused on three main long term conditions: diabetes, heart failure (HF) and chronic obstructive pulmonary disease (COPD). These have been identified to be of higher need and impact due to their complexity and increased effect on patients and the system alike.

2.7 Based on our analysis, in 2018/19 more than £20 million was spent on hospital care alone across the STP for patients with Diabetes, COPD and HF. This is an under-estimation of how much these LTCs cost the system as we only quantified visits to A&E, emergency admissions and elective admissions which were coded as being related to the three LTCs. With no change to how we support patients to self-care, this amount will almost double by 2030.

2.8 A good collaboration between service providers and patients, where patients are supported to self-care, is essential to this. The King's Fund describes this

shift as a cultural change towards ‘shared responsibility for health’ and proposes patient activation as a way to conceptualise and measure patient engagement in their own care.

2.9 The NHS Long Term Plan also highlights the need for a fundamental shift in the way care providers are working with patients and their caregivers. The report calls for a more patient-centred approach where patients are fully involved in planning their care. The 10-year long plan commits to facilitating better support for patients to improve their skills to self-care, particularly for patients suffering from long term conditions (LTCs).

2.10 Investments in building a model of care that supports patients to self-care better are proven to be very cost-effective. For example, studies looking at patient activation show that proper support in primary care results in decreasing utilisation of services, specifically in secondary care. With a 20-point increase in Patient Activation Measure (PAM) scores, evidence shows 9% fewer GP contacts (95% CI, 0.89–0.93), 20.90% fewer A&E attendances (95% CI, 0.75–0.83) and 23.3% fewer emergency admissions (95% CI, 0.71–0.83) per person (123). Moreover, increase in PAM scores also contributes to decreased length of stay, fewer hospital readmissions and reduced ‘did not attend’ rates for primary and secondary care appointments (25). For Mid and South Essex Health and Care Partnership, this means an opportunity to avoid costs of over £8.6 million by 2030.

2.11 The document contains many recommendations from page 77 to 95, however most of these are for implementation at a Mid and South Essex footprint by the ICS. These are being highlighted to the Personalisation of Care subgroup of the new ICS Population Health Improvement Board. They can be grouped into 6 themes:

1. Services that contribute to self-care across the ICS are fragmented and irregular (4.2.1)
2. Information is not readily available to patients, providers and commissioners (4.2.2)
3. Patients and primary care providers lack the capacity and skills to make the most out of their interactions (4.2.3)
4. Multimorbidity is increasing and needs to be addressed (4.2.4)
5. Funding needs to be redistributed (4.2.5)
6. Self-care as a topic is in its infancy and evidence still needs to be developed (4.2.6)

2.12 The main recommendations that can be implemented at a Thurrock place level in the current financial situation include:

1. There are some recommendations contained in the report about case finding and management, however these are superseded by the 2022 Annual Report of the Director of Public Health on the management of CVD conditions in Thurrock.

2. Education and specialist support should be provided for diagnosed patients (specific to their conditions).
3. Make aggregate data sharing with ICS partners a contractual obligation for community care providers and ensure regular data quality and completeness activities are undertaken.
4. Shift towards outcome based targets and KPIs rather than performance based.
5. Deliver motivational interviewing and other coaching techniques training to GPs and primary care staff.
6. Plan group meetings for patients with multi-morbidity to facilitate share of resources and experience.
7. Improve CBT offer for LTC patients to reduce anxiety and improve Quality of Life.

2.13 In addition there are some recommendations aimed at helping patients to get the best out of the services we offer, that could be achieved through a good communications plan. They include:

1. How to plan an appointment with care provider
2. Keeping symptom log/diary
3. Accessing free / online services
4. Being open to access support

It is also proposed that self-care forum events are run across the ICS to inform patients and carers about their role in managing their health.

## 3. Issues, Options and Analysis of Options

3.1 This needs assessment has previously been reviewed and approved by the Public Health Leadership Team, the Adults, Housing and Health Directorate Management Team, and the Mid and South Essex Health and Care Partnership Board.

3.2 As this is a needs assessment there is no requirement of the Committee in relation to options, beyond reviewing the content and offering comment.

## 4. Consultation (including Overview and Scrutiny, if applicable)

4.1 Consultation was undertaken as below:

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| **Service mapping** | Service information was collected during engagement with professional stakeholders (please see the row below for more info).<br>Additional to face to face engagement, internet search and remote liaising with provider and commissioner organisations was carried out. Each council collected information for their covered areas and |

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| | Thurrock Council Team collated the information. |
| **Professional stakeholder views** | Thurrock Council employed hosting workshops and various meetings in order to engage with local stakeholders. In addition, Essex County Council employed an online survey approach and face-to-face meetings with key professional stakeholders. There was a lack of capacity to undergo similar activity in Southend. However, the engagement included professionals serving all areas across the STP:<br><br>• Public Health Commissioners at Essex County Council, Southend Borough Council and Thurrock Council<br>• Thurrock Clinical Commissioning Group (CCG)<br>• Essex Partnership University Trust (EPUT)<br>• Adult Social Care (ASC) in Thurrock including the Community Led Support Team and the Local Area Coordination (LAC) Team<br>• North East London Foundation Trust (NELFT) Community LTC Services<br>• Healthwatch Thurrock<br>• Thurrock Community and Voluntary Services (CVS)<br>• Southend Voluntary Services (SAVS)<br>• Chronic Health Psychology Service (CHPS)<br>• Thurrock Housing Services<br>• Essex Local Pharmaceutical Committees (LPC)<br>• Basildon & Brentwood CCG |
| **Patient views** | To understand people's experience of diagnosis of an LTC, perceived barriers to self-care and what could help support them to better self-care a range of engagement activities were carried out. In Thurrock, local Healthwatch engaged with a total of 66 people through group surveys and in-depth interviews. Similarly, Healthwatch Essex engaged with 48 residents living with long term conditions using the same methods. Southend Council did not have enough capacity to commission this work. |

## 5. Impact on corporate policies, priorities, performance and community impact

5.1 This needs assessment supports delivery of the Thurrock Health and Wellbeing Strategy 2022-26 Domain 3, which focuses on person-led health and care, and the Better Care Together Thurrock adult health and care strategy.

## 6. Implications

6.1 There are no financial, legal and diversity and equality implications to this report.

We have addressed the impact on health inequalities in 7.4

All information regarding Community Equality Impact Assessments can be found here: https://intranet.thurrock.gov.uk/services/diversity-and-equality/ceia/

6.2 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

Long Term Conditions disproportionately affect individuals who are:

- Living in poverty or relative deprivation
- From certain BAME groups

What is more, our efforts to address the management of these Long Term conditions tends to be less successful in these same groups widening the gap in health outcomes.

Any efforts to support self-care would need to be targeted at these groups to mitigate against these inequalities in health outcomes.

## 7. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- This report was prepared to pull out elements of the Mid and South Essex JSNA document entitled "Self-Care in the context of living with Long Term Conditions". No other documents or papers were used in preparation though the JSNA has an extensive bibliography that should be noted.

## 8. Appendices to the report

- The full JSNA is included as a separate document.

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