

Self care for people with long term conditions



We should all care about self care

Helping people with complex and long term conditions to care for themselves has benefits for everyone. Self care can maintain people's independence and help them to lead lives that are as fulfilling as possible, while also freeing up staff time and resources to improve care in other areas.

Increasing self care support for people with long term conditions was a key commitment of the *Our health, our care, our say* White Paper, and the impetus for the more recent Supporting people with long term conditions to self care: A guide to developing local strategies and good practice.

Never have these goals been more important. There are currently more than 15 million people in England with long term health needs and, with 75 per cent more people aged 85-plus expected by 2025, this number is set to grow considerably.

Unless wholesale changes are made to the way we care for people with long term conditions, future pressures on health and social care services will be enormous. Already over two-thirds of NHS activity, and an estimated 80 per cent of costs, relate to the one third of the population with the most complex long term needs.

Promoting self care can help to relieve this pressure. Supporting patients to self care has been shown to reduce their GP visits by 40 to 69 per cent. It also significantly lowers medication intake, emergency admissions and lengths of hospital stays.

Importantly, self care is also popular with patients: recent research shows that nine out of ten people with long term health needs are interested in being more active in their own care.

However, patients need support from the NHS and social care services: there are still too many people in need of emergency care because their day-to-day care has broken down. Over three quarters

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of people with long term conditions say guidance and support from health and social care professionals would make them far more confident about taking care of their own health.

It's vital to recognise that patients with long term conditions should be involved in making appropriate choices, decisions and actions about their care. Services for these patients should include support in the following areas:

- **Information** – giving patients accessible, reliable information about their conditions.
- **Skills** – access to the Expert Patients Programme and other self-management programmes can increase patients' confidence and competence in living with their own condition.
- **Support networks** – details of local and national community and faith groups to support individuals and their carers.
- **Technology** – signposting patients to appropriate tools and devices to support self care.

When this support is combined with a partnership consultation approach, where patients feel they can participate in discussions and decisions about their care, the results can be dramatic. Greater independence is accompanied by increased life expectancy, better control of symptoms, and lower perceived pain, anxiety and depression levels. Days off work can be halved.

Alongside the improved health outcomes and quality of life afforded by self care, there are also benefits for the wider system. Investing in local self care strategies can help deliver the Public Service Agreement targets on long term conditions and older people, as well as meaning better value for money and fewer clinical interventions.

Some innovative and effective work to support self care is already taking place around the country, and having a real impact on patient outcomes.

Case study – Fred



Fred is an 80-year-old with chronic obstructive pulmonary disease (COPD). For years he has lived with his suitcase by the door in order to not delay the paramedics who respond to his emergency calls and take him to hospital.

Last year Fred was admitted to hospital on five separate occasions. The average length of stay for COPD admission is 10 days. Fred's care was expensive and of varying quality. In all cases, it was reactive, rather than forming part of a planned programme of treatment.

In November Fred was assessed by a community matron (CM). Taking his personal situation and each of his conditions into account she devised a thorough care plan for him. The plan is suited to Fred's needs rather than trying to fit him into a generic service.

Critically, the CM discovered that Fred did not understand how all of his medication worked or why it was important. The diuretics he was taking made Fred pass water often, in order to keep fluid from building up on his heart. But since Fred couldn't easily get to the loo upstairs, he stopped taking the tablets. This increased the load on his breathing and destabilised his health.

The CM has spent a lot of time teaching Fred about his condition, and helping to prevent manageable incidents leading to hospitalisation. She makes use of a method called 'Teach me back' which is advocated by NHS Employers' large-scale workforce change team. The method, which is used extensively in the USA to improve compliance with medicine regimes, helps her ensure that Fred fully understands all the information he is given.

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Another part of the CM's role is drawing together the many different care services that are provided for Fred. She co-ordinates the overall package of care from the GP practice, PCT and local authority.

During the last six months the CM has identified five occasions when Fred would have been admitted to hospital under the old way of working. Now his first call is to the CM, and his suitcase is back upstairs.

The outcome has been a better quality of life for Fred, with more co-ordinated, high quality care. He is confident that when he makes a call, his CM will call him back immediately.

Fred is back in control of his life, and the savings for everyone are clear.

- Contact Moira Ford, Workforce Governance Project Manager
020 8339 8119 Moira.Ford@kpct.nhs.uk

Case study – Birmingham OwnHealth

Birmingham OwnHealth is an innovative service offering personalised healthcare support to 2,000 people in Birmingham living with cardiovascular disease, heart failure or diabetes.



The scheme was launched earlier this year as a partnership between North and Eastern Birmingham PCTs, UK Pfizer Health Solutions and NHS Direct, to help people living with long term conditions stay fitter and healthier. Evidence suggests that one third of all coronary heart disease cases and a quarter of strokes could be prevented with appropriate exercise.

Patients in the scheme are assigned a specialist care manager who works with them to develop a personal health plan and educates them

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about their options for a healthy lifestyle. The care manager can give patients the time and support that a busy GP couldn't afford.

One of the scheme's patients is Sheila, a 63-year-old with coronary heart disease and diabetes who suffered a stroke five years ago. When she joined the programme, Sheila was keen to build her confidence, lose weight, and be able to wear more fashionable clothes.

Sheila's care manager advised her to enrol in the Exercise on Prescription programme. This scheme, introduced in 2000, offers supervised exercise programmes to cardiac patients as part of their rehabilitation. Helped by a health and fitness advisor, Sheila developed a personal activity programme of individual and group activities.

After 10 to 12 weeks, the advisor discusses the programme with the patient and sends a brief summary of their achievements to their GP. Sheila's report suggested excellent progress: she now regularly attends the gym, has started gardening, increased her daily walks, obtained a treadmill to walk at home in the evenings, and lost a total of 7lbs. Importantly for Sheila, she had also reduced her dress size.

For the NHS, the progress of Sheila and other patients on the scheme means a reduced risk of strokes, diabetes and heart disease – freeing up resources for other areas of care.

- www.phsownhealth.co.uk/ownhealth01.htm

Contact

Department of Health
Long Term Conditions Team
0113 25 45008
www.dh.gov.uk/longtermconditions



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