south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership **Held on:**	**Strategic Planning Advisory Group** **17th September 2024**
Agenda Item:	**9**
Title:	**Long Term Condition Management in South Ayrshire and Caring for Ayrshire Outcomes**

Summary:

27% of the total population of South Ayrshire have at least one physical long-term condition (LTC). Effective management of these conditions leads to best treatment and a reduction in complications leading to improved wellbeing, fewer hospital admissions and complications of these conditions. Chronic Obstructive Pulmonary Disease (COPD) and diabetes are areas of concern with lack of availability of diagnostics in COPD and long waiting lists for more advanced therapies in diabetes. Following recent work by Caring for Ayrshire the HSCP are developing plans to provide a community-based spirometry service for COPD and enhanced training for practices to be able to initiate therapies such as insulin in diabetes.

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Recommendations:

It is recommended that the Integration Joint Board

i. Note HSCP plans for long term condition monitoring and management
ii. Agree to continuation of this approach

Route to meeting:

Directions:		**Implications:**	
1. No Directions Required	☐	Financial	☐
2. Directions to NHS Ayrshire & Arran	☐	HR	☐
		Legal	☐
3. Directions to South Ayrshire Council	☐	Equalities	☐
		Sustainability	☐
4. Directions to both SAC & NHS	☐	Policy	☐
		ICT	☐

LONG TERM CONDITION MANAGEMENT IN SOUTH AYRSHIRE AND CARING FOR AYRSHIRE OUTCOMES

1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform the IJB of recent Caring for Ayrshire meetings and outcomes and the Health and Social Care Partnership response to these outcomes in terms of improving long term condition management in particular in the areas of COPD and Diabetes.

2. RECOMMENDATION

2.1 It is recommended that the Strategic Planning Advisory Group:

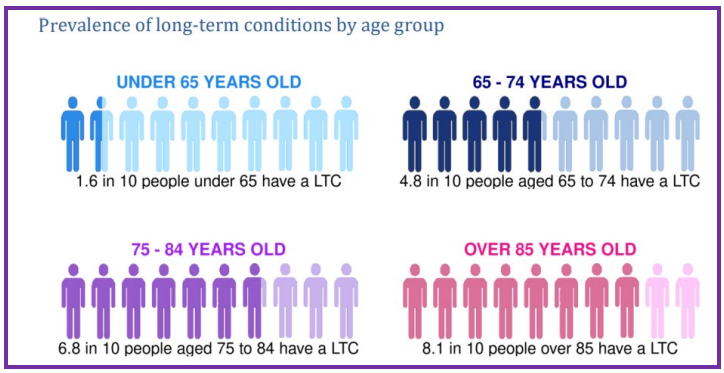
i. Note HSCP plans for long term condition monitoring and management
ii. Agree to the continuation of this approach

3. BACKGROUND INFORMATION

3.1 In the financial year 2018/19, in South Ayrshire HSCP, 27% of the total population had at least one physical long-term condition (LTC). These include: cardiovascular, neurodegenerative, and respiratory conditions, as well as other organ conditions (namely liver disease and renal failure), arthritis, cancer, diabetes, and epilepsy.

3.2 Long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40) (Kings Fund).

3.3 South Ayrshire's LTC prevalence by age is in table below:



3.4 Long-term conditions are more prevalent in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease). (KF)

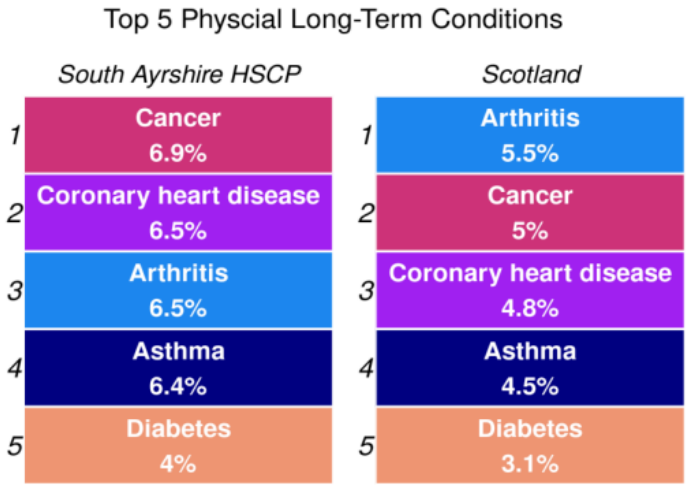
3.5 Most individual long-term conditions are more common in people from lower socio-economic groups, and are usually more severe even in conditions where prevalence is lower – for example, stroke.(KF)

3.6 People with long-term conditions now account for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.(KF)

3.7 Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure (KF)

3.8 The Table below shows South Ayrshire as having higher rates of the 5 most common LTCs than Scotland. This will be to some extent, a reflection of the age profile.

Table 6: Prevalence of the five most common physical LTCs as a percentage of the population across geographical areas (where 1 = most prevalent).



3.9 Caring for Ayrshire identified 5 priority areas and a series of meetings occurred to develop project charters for Diabetes, Fraility, Palliative Care and End of Life, Rehabilitation and Respiratory. For the purposes of this report I am only discussing Diabetes and COPD since these are areas where the most obvious gaps exist that might be filled within primary care.

3.10 Hollyheath App has been used in part to address the poor uptake of chronic disease monitoring since the COVID pandemic. Non essential care stopped abruptly in early 2020 and although all practices have resumed long term condition monitoring, levels of response to annual review invitations have not yet reached pre-pandemic levels. Almost 2000 residents have responded to invitations from their general practice to download the app, just over 50% of app users are over 55 and 64.4% of app users report having a physical health condition.

4. REPORT

4.1 Spirometry is the investigation required to diagnose COPD. Some practices perform spirometry but there are concerns about reliability and accuracy. Not

all residents have access to this test via their practice and there is no referral route from practices to have the test done within secondary care. We are developing a community spirometry service to allow diagnosis of those with symptoms and catch-up of those diagnosed clinically without investigation. The partnership's innovation budget will fund an 18 month pilot to allow up to 1000 spirometry tests to be carried out at locations within each locality.

4.2 Only one practice has the skills required to initiate insulin in patients with type 2 diabetes. We are developing a pilot whereby an experienced nurse will train practice nurses in other practices to initiate insulin thus reducing numbers on (years) long hospital waiting lists, improving diabetic control and reducing the risk of significant complications including blindness, amputation, kidney failure.

4.3 Taken together these initiatives should significantly improve outcomes for patients with these conditions, with the secondary benefits of reducing acute hospital admissions, prescribing costs, debility and associated costs to society and health of complications.

5. STRATEGIC CONTEXT

5.1 These plans have been developed with Caring for Ayrshire principals at their core with equality of access for all residents. Spirometry will be performed in each locality at a suitable venue with easy public transport access. Higher level diabetes care will move from hospital outpatients to a patient's general practice.

6. IMPLICATIONS

6.1 Financial Implications

6.1.1 The costs of these projects will be met from the partnership's innovation fund. Estimated costs for the 18-month COPD project are around £60,000. The Hollyhealth app cost £10,000 in its 1st year with a renewal cost of around £18,000. Planning for the diabetes project is less advanced but costs are likely to be around £300 per patient initiated on insulin.

6.1.2 Should these pilots be successful a business case will be made for ongoing funding by means of reduced prescribing costs and fewer acute hospital bed days. If the community spirometry pilot is successful in South Ayrshire the intention would be to roll it out on a pan Ayrshire basis.

6.2 Human Resource Implications

6.2.1 Recruitment of staff for spirometry service will be required and the project has involved HR, particularly looking for staff in redeployment who might be suitable for a fixed term role. The diabetes project relies on a recently retired person who will deliver training and support to practices.

6.3 Legal Implications

6.3.1 Nil known

6.4 Equalities implications

6.4.1 Nil known

6.5 Sustainability implications

6.5.1 Nil known

6.6 Clinical/professional assessment

6.6.1 These projects have been developed by clinical director working alongside consultant respiratory physician, consultant in public health, managed clinical networks and other key stakeholders to ensure good governance and will be evaluated.

7. CONSULTATION AND PARTNERSHIP WORKING

7.1 Reports have been taken to DMT.

7.2 I have worked with Partnership Chief Officer to develop this report.

8. RISK ASSESSMENT

8.1. N/A

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APPENDICES

N/A

BACKGROUND PAPERS

N/A