1. BACKGROUND

1.1 DRIVERS FOR CHANGE: THE INCREASE IN LONG TERM CONDITIONS (LTCs) IN SCOTLAND

WHilst LTCs are most prominent in older people they are increasing in all age groups in Scotland, and are higher in people living in areas of high deprivation and people from Black and Minority Ethnic Communities (1).

The WORLD HEALTH ORGANISATION has stated that managing long-term conditions is the biggest challenge facing healthcare systems worldwide, given that over 60% of all deaths attributable to them, and that they can limit a person’s lifestyle, opportunities and potential.

1.2 NHS SCOTLAND’S STRATEGIC POLICY RESPONSES

In 2005-2006 following the publication of the ‘Kerr Report’ and ‘Delivering for Health’ health policy in Scotland identified a number of key ‘Principles of Good Long Term Conditions Management’. These included:

• Focus on the whole person – take a more holistic approach
• Primary Care is the key – Improve co-ordination in Primary Care
• Use good information systems and management
• Review care using evidence based protocols and guidelines
• Involve community and voluntary resources
• A well-trained workforce is a re-skilled workforce
• Community Health Partnerships (CHPs) offer significant opportunities for providing systematic integrated care - and need support

2. MENTAL HEALTH, MENTAL WELL-BEING and LTCs: WHY THEY MUST BE ADDRESSED COLLECTIVELY

Research has established that people living with an LTC are at greater risk of developing mental health problems with approximately 30% developing depression and/or anxiety which can negatively affect management and outcomes of LTCs (1, 2, 3).

Despite the above association being known for some time, organisations like Long Term Conditions Alliance Scotland (LT CAS) point out that the mental health needs of people with LTCs are still not being adequately addressed.

• Recognition of psychological distress is an important feature of general practice but recent research in Scotland has found that around half of patients with significant symptoms were not identified by their GP as suffering from a depressive disorder (4).

3. THE LIVING BETTER PROJECT’S FOCUS GROUPS

• Working with 5 CHPs and 10 GP practices across rural and urban Scotland, patients with diabetes and/or CHD & COPD have been/ will be randomly selected from Diabetes, CHD and COPD registers. To date 24 focus groups, 17 with patients (involving over 130 people) and 7 with nurses. Greater mental health and mental well-being awareness training.

4. SUMMARY of KEY FINDINGS FROM HEALTH PROFESSIONAL FOCUS GROUPS

• The Quality Outcomes Framework (QOF) mental health questions and pre-questions are too basic/crude and some professionals feel awkward asking them, both with patients they know and don’t know well.

• After using HADS or PHQ 9 as part of the QOF, if patient scores showed depression/risk of depression, many nurses said the scores were passed on to other services. They said they were not notified of the scores.

• Greater recognition of depression and mental health needs within the clinical setting.

5. INITIAL CONCLUSIONS FROM FOCUS GROUPS

• As the above chart shows more and more consultations in primary care involving people with CHD and/or diabetes & COPD are with practice nurses. Greater mental health and mental well-being awareness training should be provided to these nurses.

• Social support is a non-complex, low cost intervention. It has the potential to bring significant benefit to these patients. Greater consideration of this important aspect of mental health and well-being, during prevention, screening, assessment and treatment must be increasingly considered for patients with CHD and/or diabetes & COPD.