Enhancing the Quality of Life for People Living with Long Term Conditions

Long Term Conditions are those that cannot, at present, be cured, but people living with these conditions can be supported to maintain a good quality of life.

People aged over 85 years are more likely to be living with a long term condition including frailty.

% of population in England aged over 85 years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>2.4</td>
<td>2.5</td>
<td>2.6</td>
<td>2.8</td>
<td>3.3</td>
<td>3.8</td>
<td>4.1</td>
<td>4.2</td>
<td>4.4</td>
<td>4.6</td>
<td>4.6</td>
</tr>
</tbody>
</table>

People might be living with more than one long term condition. Of the people who report that they live with long term conditions:

- 24% have two long term conditions...
- ...and 20% live with three or more long term conditions.

However many conditions people are living with it is important that they feel supported to manage their overall health and wellbeing. They should have a care planning discussion recorded in a written care plan.

72% of people with long term conditions use their care plan to manage everyday health

People living with a long term condition are less likely to be working than the general population.

72% of the general population are in work

59% of people with long term conditions are in work

35% of people with a mental health condition are in work

51% of people die in their preferred place of care

People should have opportunities to discuss their wishes and preferences for now, and for the future, and to have these recorded in a personalised care plan.

50% of all GP appointments

64% of all hospital outpatient appointments

70% of all hospital bed days

70% of total health and social care spend

More information about enhancing the quality of life for people living with long term conditions can be found at: [www.england.nhs.uk/house-of-care/](http://www.england.nhs.uk/house-of-care/)
International Research to Evidence Innovation

Four audiences, 13 markets:
- Survey of 25,355 patients
- Survey of 2,659 healthcare professionals
- > 300 qualitative interviews

Reduction in emergency admissions and secondary care cost for the top half of the pyramid.

90% of patients feel more in control.

The higher up the pyramid the more immediate the effect.

Patients who report more control are 6.5x more likely to report a decrease in healthcare utilisation than patients who do not.
International Research to Evidence Innovation

Collaborative care for complex chronic patients

Survey of 25,355 patients
Survey of 2,659 healthcare professionals
> 300 qualitative interviews

Four audiences, 13 markets:

Future health index

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>FHI (0-100 Points)</th>
<th>Access (0-100 Points)</th>
<th>Integration (0-100 Points)</th>
<th>Adoption (0-100 Points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>United Arab Emirates*</td>
<td>65.3</td>
<td>72.1</td>
<td>60.0</td>
<td>63.9</td>
</tr>
<tr>
<td>2</td>
<td>The Netherlands</td>
<td>58.9</td>
<td>72.4</td>
<td>58.8</td>
<td>45.5</td>
</tr>
<tr>
<td>3</td>
<td>China</td>
<td>58.1</td>
<td>64.8</td>
<td>57.3</td>
<td>52.1</td>
</tr>
<tr>
<td>4</td>
<td>Australia</td>
<td>57.9</td>
<td>71.5</td>
<td>55.1</td>
<td>47.2</td>
</tr>
<tr>
<td>5</td>
<td>Singapore</td>
<td>57.7</td>
<td>70.1</td>
<td>54.8</td>
<td>48.2</td>
</tr>
<tr>
<td>6</td>
<td>United States</td>
<td>57.4</td>
<td>68.4</td>
<td>54.7</td>
<td>40.0</td>
</tr>
<tr>
<td>7</td>
<td>Sweden</td>
<td>57.3</td>
<td>64.0</td>
<td>60.9</td>
<td>46.9</td>
</tr>
<tr>
<td>8</td>
<td>South Africa</td>
<td>56.7</td>
<td>63.2</td>
<td>55.3</td>
<td>51.6</td>
</tr>
<tr>
<td>9</td>
<td>United Kingdom</td>
<td>56.4</td>
<td>70.2</td>
<td>53.7</td>
<td>45.3</td>
</tr>
<tr>
<td>10</td>
<td>France</td>
<td>54.6</td>
<td>66.9</td>
<td>54.4</td>
<td>42.6</td>
</tr>
<tr>
<td>11</td>
<td>Germany</td>
<td>54.5</td>
<td>69.2</td>
<td>52.8</td>
<td>41.5</td>
</tr>
<tr>
<td>12</td>
<td>Brazil</td>
<td>50.6</td>
<td>45.4</td>
<td>57.0</td>
<td>49.4</td>
</tr>
<tr>
<td>13</td>
<td>Japan</td>
<td>49.0</td>
<td>57.9</td>
<td>50.7</td>
<td>38.4</td>
</tr>
</tbody>
</table>

13 market average 56.5  65.9  55.8  47.8

Evidence for Supported Self Care at Scale

Service Hub

15,000,000 data points every month

Populating adherence.

1808 patients in the study cohort

Average Age

Average Risk of Emergency Admission

66% 26% 43% 11% 60% 50%
Philips defines population health management in this way:

“The organization of and accountability for the health and healthcare needs of defined groups of people utilizing proactive strategies and interventions that are coordinated, engaging, clinically meaningful, cost-effective, and safe.”
The self-care hub

“I have one first point of contact. They understand both me and my conditions.”

“I am supported to understand my choices and to set and achieve my goals.”

“When I move between services or settings, there is a plan in place for what happens next.”

“I have systems in place to get help at an early stage to avoid a crisis.”

“I have information, and support to use it which helps me manage my conditions.”

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”
Bill:
Awareness and prevention
“I used to smoke and managed to quit.”
“I want to stay healthy and enjoying life”

Connie:
Reminders and Coaching
“Remind me what I need to do”
“I like feedback and advice”

David:
LTC management
“I want peace of mind”
“I want to regain my confidence”
“I want to walk to the shops again”
Bristol Community Health is a social enterprise and the leading provider of NHS community healthcare services in Bristol, providing over 35 services.

Community services include district nursing, specialist nursing, long term conditions, intermediate care, urgent care, therapies.

Majority of patient contacts are in their own homes.

Community healthcare teams are integrated into - and aligned with - general practices/clusters.
How did we do it – and why?
Rationale and deliverables

- Building experience, evidence and assets locally
- Translate learning from elsewhere to the Bristol healthcare environment
- Build on Telehealth and demonstrate wider benefits of a more comprehensive programme
- 1/50th scale (one practice) realisation of a Supported Self-Care programme for the whole of Bristol.
- Map out pathways and care coordination objectives
- Resourced by BCH and Philips and financially supported by WEAHSN
- Lennard practice part of previous Telehealth pilot, saw benefits and keen to expand service to further improve care

**Deliverables:**

- Specification for the Self-care Hub
- Stakeholder engagement
- Recruitment methodologies
- Cohort based programmes
<table>
<thead>
<tr>
<th>Cohort</th>
<th>N = 74</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| A and B | 22     | • Severe COPD, HF or diabetes, likely to have >1 ED admission in following year  
• Motiva – average length 5.5 months  
• On average, patients alerted to the ‘hub’ every other day  
• Most watched all videos  
• Age range: 58-88, Average: 76 |
| C      | 35     | • COPD, HF, Diabetes or Hypertension, at some risk of deterioration  
• Flo – average length 15 weeks  
• Messages exchanged = between 3 and 6 per day  
• Hub clinician reviewed patient input 1 – 2 times per week, with patient contact made if necessary  
• Age range: 33-83yrs, Average: 62 |
| D      | 17     | • Patients with a diagnosed condition (diabetes, pre-diabetes, overweight/obesity etc) and high risk of future health deterioration. Low risk of admission  
• uMotif – average length 15 weeks  
• Hub clinician reviewed level of engagement at regular intervals with support and encouragement provided  
• Age range: 35-69yrs, Average: 51 |

(93 patients enrolled in total but not all became regular users)
Evaluation

- Patient baseline & exit questionnaires based on LTC6, including carer question
- Patient Activation Levels
- Patient satisfaction survey
- Clinician questionnaires
- Health care utilisation pre & post intervention
- Weight, BP, HbA1c pre and post
- Patient stories & Case Studies
- Patient profiles – what works and for whom
It keeps me out of hospital.
That’s one of the main reasons I volunteered to go on this scheme.

Gordon, patient
May 2015

Helping you to live life well
Key results

- Reduction in A&E attendances and unplanned admissions – 50% in Motiva group
- Reduction in primary care activity levels - largest in the Motiva group
- Increase in patient activation levels – largest in the Flo group
- Reduction in HbA1c – with most success in the Flo group.
- High patient satisfaction:
  
  "It’s made me more aware of my own condition, I’ve learned to read the signs. Able to judge when I need to contact someone”

- "My whole behaviour towards diabetes has changed. It's educated me in a lot of ways. I'm also losing weight which is one of the big contributing factors to Diabetes. Because you're taking more notice of it, it makes you react.”

cont…
Key results continued

• High clinician satisfaction - 100% of clinicians reported that it made their consultations and management of patients more effective

• “Seems to reduce his anxiety and the number of (previously very frequent and long) phone calls” - GP

• “Look at the improvement in Hba1c since started with Flo!!!, “HbA1c gone from 97 to 77!””
  - PN

• ‘Nudging’ psychology of text messaging popular
Lessons for scaling up

- One size does not fit all
- Menu of programme options *personalised* for each patient
- Co-creation with GPs
- Clinical engagement important in patient selection
- Skill mix of the ‘hub’
- Mail shots and marketing to target lower risk cohorts (hardest to recruit)
- Integrated information flow
The Champion Project results show

- The Hub can make patient management and clinicians’ use of time more efficient
- The programme works with a population-wide approach
- There has been a reduction in GP, nurse and secondary care demand
- Improvements in patient engagement/activation, confidence, awareness and management of their condition and symptoms
- Improvements in clinical parameters
Thank you!