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Self Management of Long Term Conditions

Southend-on-Sea Patient Activation Pilot

One of the central drivers to address health inequalities and improve population health and wellbeing is “placed-based approaches”, delivering local solutions through collaboration with local partners, and building community resilience.

This report is one such example of how we are leading the way to deliver local, collaborative and evidence based services addressing the increasing population needs of those experiencing one or more long-term health condition. A full pilot programme evaluation will be published in due course and this report provides an insight to the programme’s success.

The Department of Health is asking all Clinical Commissioning Groups to promote the use of patient activation within their areas. Southend has worked with self management uk to develop and pilot an innovative use of patient activation that is able to focus resources effectively for those living with long-term conditions.

INTRODUCTION

Thirty-one per cent of people in Southend-on-Sea report having at least one long-term condition (LTC) and Southend-on-Sea has a higher share of people with three or more LTCs (12.9%, compared to the national average of 10.5%). Patients with long-term conditions are the most intensive users of health and social care services and account for around 70% of the total health and care spend in England.

Self management uk, a registered Charity, is a National provider of long-term health condition self-management interventions. It originally grew out of the Department of Health’s Expert Patient Programme, subsequently became a Community Interest Company and in 2014 became an independent charity. It has delivered programmes for over 130,000 people around the country and is widely recognised as a leading player in this field. In 2015 self management uk collaborated with Southend-on-Sea Borough Council and NHS Southend CCG to deliver a pilot LTC programme focussed on promoting better self-management and

developing local volunteers within the Borough as part of wider programme to address the impact of LTCs on the Southend health and care system.

Improving the ability of patients with long-term conditions to self-manage, address modifiable risk factors, and adhere to clinical care protocols with appropriate use of prescribed medication, has been shown to improve their health and wellbeing and reduce costs to health and social care systems. There is strong evidence that people living with long-term conditions are able to self-care if they are provided with appropriate guidance, are motivated and have access to the required support. This pilot programme was focussed on increasing the knowledge, skills and confidence of people to take action to address issues impacting on their health.

The term 'Patient Activation' is commonly used to describe how well a person can manage their own health and health care. People who are less activated (ready) to change negative health related behaviours, have health and social care costs approximately 8 percent higher than more activated individuals. Their costs are also 21 percent higher in the subsequent follow-up year.

METHODOLOGY

PATIENT IDENTIFICATION AND TRIAGE TO SELF-MANAGEMENT INTERVENTIONS

Seven General Practices were invited to participate in a pilot programme and subsequently agreed to provide the programme's patient cohort. Each General Practice provided a list of patients through clinical patient data systems. The patient inclusion criteria were set against the following long-term health conditions, all identified in a pre-programme population needs assessment carried out by the Southend-on-Sea Public Health Team:

- Patients aged 19 to 74 (except for Asthma which was 40 to 74)
- Hypertension
- Diabetes
- Chronic Kidney Disease
- COPD
- Depression
- Mental health
- Chronic Pain
- Carer
- Exclusions were those on palliative care registers and those registered to a nursing home

PHASE 1: TRIAGE TO SELF-MANAGEMENT INTERVENTIONS

The Patient Activation Measure (PAM) Tool was used as an evaluation tool to assess the impact on an individual's level of activation at three stages: initial triaging for referral to a range of self-management interventions offered of varying levels of intensity; after attending a self-management intervention and triaging onward referral to community health and social care support services after completion of the self-management intervention.

The self-management interventions offered were:

- 6 x Self Management for Life (SM4L) patient education courses: 6 weeks in duration, 2 ½ hours per week.
- 10 x Self Management for Life (SM4L) – Health Awareness workshops: 3 weeks in duration, 2 ½ hours per week.
- 1 x Market Place Health Event: full day workshops and seminars providing information and advice on local services and support they could access for self-management.

A total of 14,411 patients were referred to self management uk and segmented by the number of long-term health conditions they exhibited.

5,271 (37%) patients had diagnoses of 2 or more conditions of which 374 were contacted with an invitation to participate in the pilot programme.

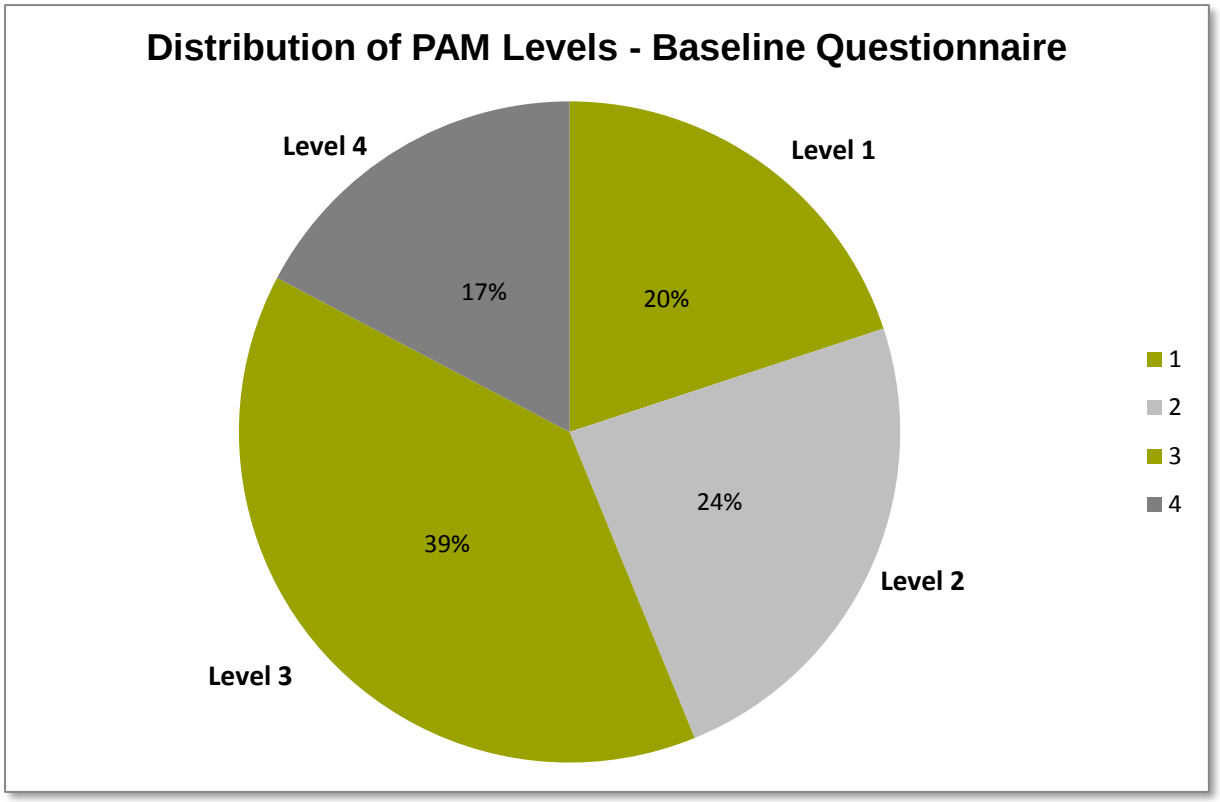
The self-completed PAM tool is used to get an initial baseline of knowledge skills and confidence to take action to improve their health. People are categorised into 4 levels of activation:

Level 1: passive and overwhelmed by managing their own health. They may not understand their role in the care process.

Level 2: lacking the knowledge and confidence to manage their health.

Level 3: taking action but may still lack confidence and skill to support their behaviour

Level 4: have adopted many of the behaviours needed to support their health but may not be able to maintain them in the face of life stressors.



Patients with a PAM Score of 1 were invited to attend a 3 week self-management course (facilitated sessions with expert tutors trained to support people to self-manage)

Patients with a PAM Score of 2 were invited to attend a 6 week self-management course (facilitated sessions with expert tutors trained to support people to self-manage)

Patients with a PAM Score of 3 or 4 were invited to attend a Market Place Event (full day workshops and seminars providing information and advice on local services and support they could access for self-management. Practical demonstrations on healthy eating, stopping smoking, weight management support and advice from the community and voluntary sector groups, national and local charities as well as statutory services such as housing, debt advice and support etc.)

PHASE 2: POST INTERVENTION TRIAGE AND ONWARD REFERRAL

On completion of the self-management interventions, patients' PAM Levels were re-assessed and used as a basis for onward referral to a portfolio of community and statutory health organisations providing support services including mental health, COPD, Diabetes, Diet and exercise and smoking cessation.

An interim analysis of the post intervention follow-up indicates 37% of patients who attended a self-management intervention with a baseline PAM Level of 1, 2 or 3, recorded a PAM Level increase of between 1 and 3 Levels

PHASE 3: PILOT PROGRAMME EVALUATION AND NEXT STEPS

A full evaluation of the pilot is currently being undertaken by the Southend-on-Sea public health department and the intention is to provide a full breakdown of NHS and Social Care interaction (hospital attendance, admission etc.) of patients who have been part of this pilot. This data will be used to calculate the cost effectiveness of the interventions offered in addition to the model of delivering services.

Additional PAM tool follow-up assessments will be carried out at 3 months post attendance at a self-management intervention, and patients who referred to community and statutory health service providers will be tracked to establish their interaction and engagement with these services.

The interim follow-up PAM tool analysis has established increases in PAM levels indicating the success of the programme. Importantly, a number of improvements to the preventative health services and pathways have been identified. These improvements will be available to the wider community. Health services within Southend-on-Sea will have more support and services they can call on to signpost or refer patients for lifestyle intervention as a result of this pilot project.

This is one example of how, through collaboration between Public Health, Clinical Commissioning, community health providers and self management uk, we can deliver innovative, cost effective and evidence based interventions and models of service delivery that provide local solutions in addressing the challenges that supporting those with long-term conditions present.

self management uk are now keen to work with other local communities to utilise the learning from Southend-On-Sea and to roll out a second phase of programmes.

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