Cornwall self-management model

Enabling people with long term conditions to take control of their health

SHAPING OUR FUTURE

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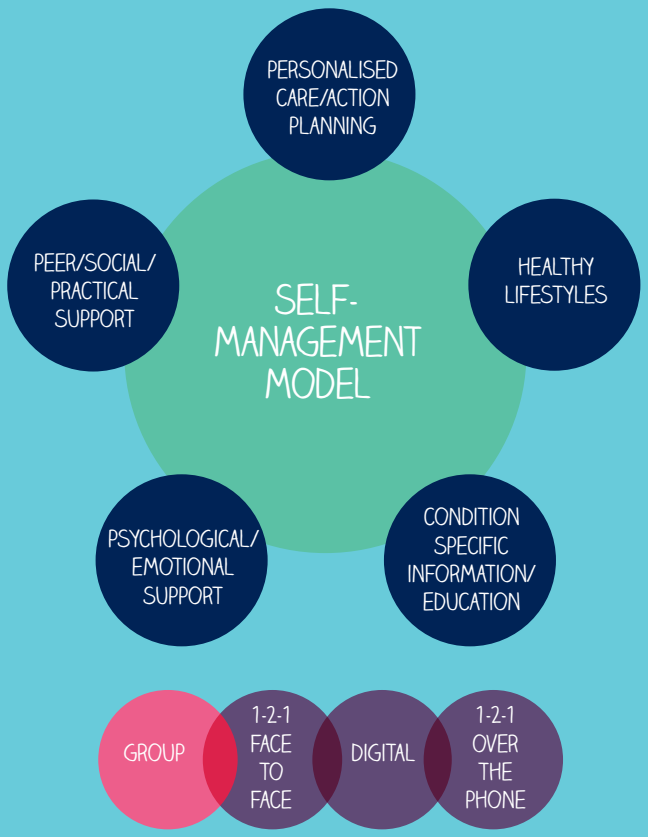
workforce skills

organisational culture

evaluation: e.g. patient activation measure

tackling inequalities



range of intensity based on need

"CO-PRODUCTION IS A WAY OF WORKING THAT INVOLVES PEOPLE WHO USE SERVICES, CARERS AND COMMUNITIES IN EQUAL PARTNERSHIP"

"GOOD MENTAL WELLBEING IS INTEGRAL TO GOOD SELF-MANAGEMENT"

CONTENTS

INTRODUCTION AND AIMS

This report summarises the strategic vision and action plan for the self-management of long term conditions (LTCs) in Cornwall. The aim is for Cornwall to have a flourishing system that supports self-management, and for people and communities to be empowered to take control of their health and wellbeing.

This self-management model has been co-produced by the Cornwall Self-Management Leadership Group, a collaboration of people with experience of long term conditions, the community and voluntary sector, clinicians, public health and commissioners.

Co-production is a way of working that involves people who use services, carers and communities in equal partnership, engaging groups of people at early stages of service design, development and evaluation. It is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care and person-centred care. It is ongoing, not a one-off process.

Co-production promotes a culture where certain values and behaviours are the norm (Figure 1)[1]

Figure 1: Co-production values

The model is informed by the Self-Management of Long Term Conditions Needs Assessment Report, which brings together research, local data and community views on self-management[2].

The model is not exhaustive, but can be used as a framework in the following ways:

- To map support and identify gaps
- To develop new support
- To track progress and make improvements
- To generate ideas - leadership can come from anywhere across the system

According to the Department of Health, long term conditions are 'those conditions that cannot, at present, be cured but which can be controlled by medication and other therapies'. Managing a long term condition can take considerable effort and time. Only a fraction of the time spent managing a condition is supported by a health professional. Most of the time people manage their condition on their own, or with the help of family, friends and community. The voluntary sector has a key role to play in enabling self-management.

Growing national policy and evidence shows the benefit of enabling people to manage their own health. The benefits are felt by people with long term health conditions, health professionals, providers and commissioners. Together with good quality clinical care, self-management helps people manage the physical, emotional and social impact of their long term health conditions at different stages and ages during their lives.

[1]NHS England, A Coproduction Model. Available at: https://www.england.nhs.uk/participation/resources/co-production-resources/ [Accessed 23.08.2018].

[2]Available at https://www.cornwall.gov.uk/health-and-social-care/public-health-cornwall/joint-strategic-needs-assessment-jsna/

Self-management - Scope and definition

> "SELF MANAGEMENT INCLUDES ALL THE ACTIONS TAKEN BY PEOPLE TO RECOGNISE, TREAT AND MANAGE HEALTH AND WELLBEING INDEPENDENTLY OF OR IN PARTNERSHIP WITH THE HEALTH AND SOCIAL CARE SYSTEM" (NATIONAL VOICES)

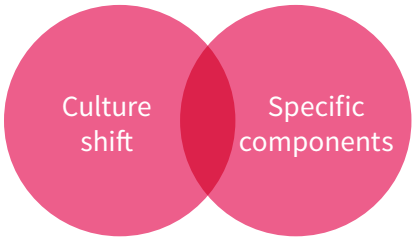
Self-care and self-management are important across the life-course. The terms are often used interchangeably, but self-care usually refers to looking after one's health and wellbeing with or without a diagnosed condition, whereas self-management usually refers to managing a diagnosed health condition, which is the definition used in this report.

The scope of this model covers self-management in adults after diagnosis of **four physical long term conditions**. It uses the example of four physical long term conditions which represent a considerable burden to individuals and the health system: diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and cancer. Good self-management of these conditions could make a huge difference to people's quality of life and health outcomes. Mental wellbeing is included as a key determinant and consequence of self-management of long term physical health conditions.

This strategy is a springboard to action across LTCs; these conditions are just a starting point. Additionally, some types of self-management, for example healthy lifestyle support, are relevant across conditions.

Self-management is not one single approach. It cannot be prescribed or put in a package, like a medicine. It is a culture shift, with professionals moving from "What's the matter with you?" to "What matters to you?", and with individuals becoming empowered and confident to manage their own health rather than rely solely on professionals. But we know there are specific components or interventions that can be put in place to make self-management easier. And the effectiveness of self-management depends on how intensively the approach is implemented and embedded, so we need engagement and partnership working across communities and organisations, and a common understanding of and commitment to self-management. Self-management can therefore be thought of as both **culture shift** and **specific components** (figure 2).

Figure 2: Self-management as culture shift and specific components



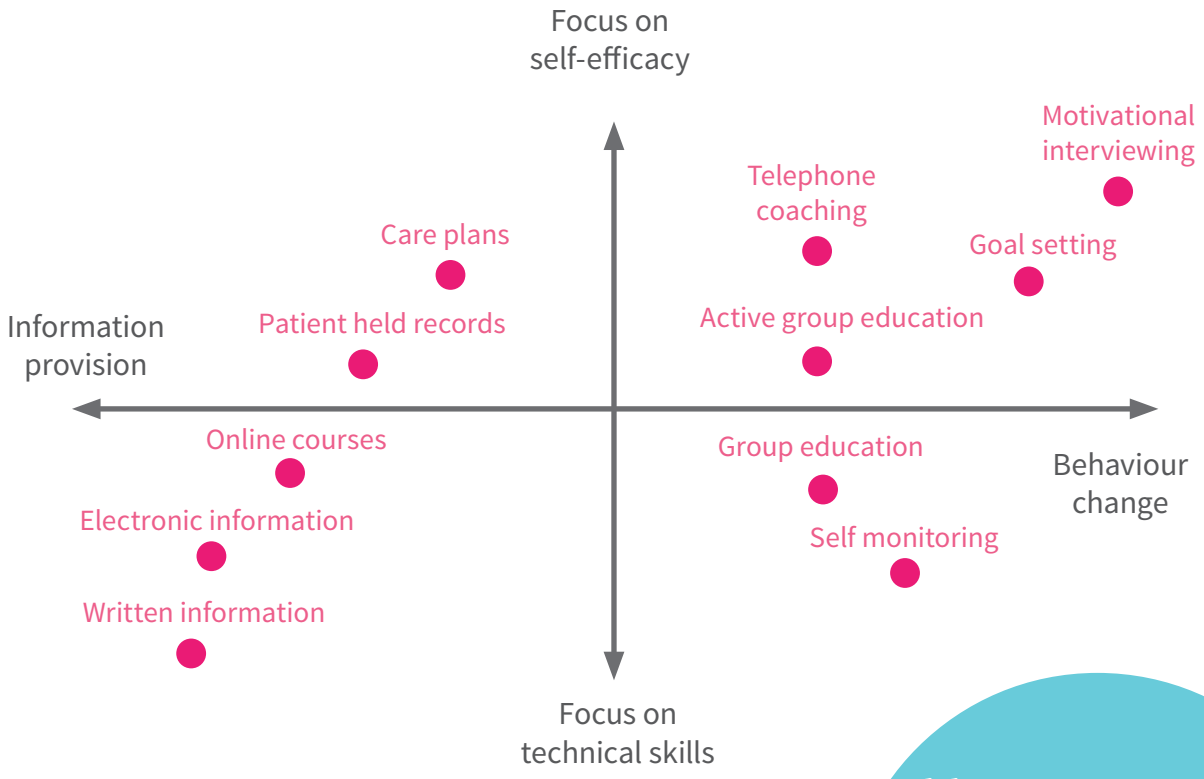
Examples of specific self-management components include[3]:

- providing self-management education for people with specific conditions
- interactive online self-management programmes
- telephone support and telehealth initiatives
- self-monitoring of medication and symptons

Self-management strategies can range from information provision to more intensive behaviour change, and from a focus on technical skills to a focus on self-efficacy (figure 3).

[3]National Voices (2015) Supporting Self-Management. Available at: https://www.nationalvoices.org.uk/sites/default/files/public/publications/supporting_self-management.pdf [Accessed 23.08.2018].

Figure 3: Continuum of strategies for self-management support[4]



"GROWING NATIONAL POLICY AND EVIDENCE SHOWS THE BENEFIT OF SUPPORTING PEOPLE TO MANAGE THEIR OWN HEALTH."

[4]De Silva D. (2011) Helping people help themselves. London: The Health Foundation/Evidence Centre. Available at: https://www.health.org.uk/sites/health/files/HelpingPeopleHelpThemselves.pdf [Accessed 23.08.2018].

National context

The **NHS Five Year Forward View** sets out a clear ambition for the NHS to become better at helping people to manage their own health. To meet this commitment, NHS England is making supported self-care a key part of their strategy to personalise care. This involves increasing support for people living with LTCs to manage and make decisions about their own health and wellbeing. It also promotes health and wellbeing, prevention and self-care as the foundation of a sustainable health and social care system.

The **NHS Constitution for England** says that people have the right to be involved in discussions and decisions about their healthcare and to be given information to enable them to do this.

The **Health and Social Care Act** requires all health and social care providers to, where appropriate, provide opportunities for service users to manage their own care or treatment; and provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement.

The **Care Quality Commission**, which regulates the quality of health and social care on behalf of patients, service users, their carers and families, has issued guidance to providers on meeting the statutory requirements to enable people to have choice and control and to manage their own care.

The **General Medical Council** says doctors should support people in caring for themselves to improve and maintain their health. Good Medical Practice suggests: "This may include advising patients on the effects of their life choices on their health and well-being and the possible outcomes of their treatments."

The **Nursing and Midwifery Council** says nurses and midwives "must support people in caring for themselves to improve and maintain their health."

The challenge relating to long term conditions and a move to self-management and co-production are **global**. Examples can be seen in the New Zealand self-management model, the Welsh Prudent Healthcare movement, and the Choosing Wisely Canada movement.

NHS England have set out what success in 2020 would look like for supporting people to manage their own health, wellbeing and care[5].

1. **Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices**

- Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action.
- Patients and clinicians are supported by decision aids to help people think through the pros and cons of different care, treatment or support options.

2. **Care planning and self-management is hardwired into how care is delivered**

- Meaningful care planning takes place for people with long term conditions or ongoing care needs which guides the choices and actions of the patient and her/his professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or carers.
- People living with long term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing, including:
    - Self-management education: formal education or training so people develop knowledge, skills and confidence to manage their own health and wellbeing
    - Peer support: people supporting each other to understand their condition(s) and to manage its impact
    - Health coaching: to help people set goals and take action, improving their health and lifestyle
    - Group based activities: activities that encourage healthier living and reduce social isolation (e.g. exercise classes or community choirs).

[5]NHS England, STP aide-memoire: Supporting people to manage their own health, wellbeing and care. Available at: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/01/stp-own-health.pdf. [Accessed 23.08.2018].

3. **Social action beyond the NHS helps people improve their health and manage their wellbeing**

- The STP area works with their local authority to support the local population in building community capacity and resilience.
- Social prescribing is widely provided by primary care and whole population care models.
- Strong partnerships between the NHS and voluntary groups deliver prevention approaches and support for patients, carers and their families.
- STPs employ asset based approaches: community-based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing.

Local context

Shaping Our Future

The vision of Shaping Our Future is:

> "WORKING TOGETHER TO ENSURE THE PEOPLE OF CORNWALL AND THE ISLES OF SCILLY STAY AS HEALTHY AS POSSIBLE FOR AS LONG AS POSSIBLE; SUPPORTING PEOPLE TO HELP THEMSELVES AND EACH OTHER FOR LONGER-LASTING INDEPENDENCE; AND PROVIDING SERVICES THAT EVERYONE CAN BE PROUD OF AND THAT REDUCES OVERALL COST TO THE SYSTEM"

Self-management is a key part of the Kernow STP Outline Business Case, alongside addressing the wider social-economic determinants of health and healthy lifestyles, and sits under the New Model of Care workstream.[6] This includes a commitment to "create a self-care service to inform, enable and support people to manage their own care. There will be structured education programmes for Long Term Conditions (LTC) and Patient Activation Measures (PAM) will be used to identify those able to manage their LTC and patients where more support is needed."

Self-management also underpins the Cornwall Council Strategy, which has five priority areas including better health for everyone[7], and the Adult Social Care Framework "Community Based Support and Housing Framework 2017-2025."[8]

Health needs

Nationally an estimated 15 million people (over a quarter of the population) have at least one LTC. LTCs are more prevalent in older age groups.

- People from deprived backgrounds are more likely to have two or more conditions (multi-morbidity).
- An estimated 81,654 people in Cornwall (29.7% of the population) have two or more LTCs, and 348 people in the Isles of Scilly (31.4% of the population).
- 67.5% of people are feeling supported to manage their condition (the England average is 64%). The Cornwall Residents survey shows confidence to manage health varies by age, with 65+yrs (43%) saying they are very confident in managing their health, dropping to 26% for those who were 85+yrs.
- Health-related quality of life for people with LTCs is 0.73 (average EQ-5D score), similar to the England average of 0.74.
- At least 30% of people with a physical long term condition also have a mental health problem.

[6]Cornwall Council (2016) Cornwall and the Isles of Scilly Sustainability and Transformation Plan: Draft Outline Business Case. Available at: https://www.cornwall.gov.uk/media/22984634/cornwall-ios-stp-draft-outline-business-case.pdf [Accessed 30th July 2018].
[7]Cornwall Council (2018) Cornwall Council Business Plan (2018 – 2022). Available at: https://www.cornwall.gov.uk/media/31517040/cc-business-plan-final.pdf [Accessed 31st July 2018].
[8]Cornwall Council (2017) Adult Transformation and Commissioning Service Community Based Support and Housing Commissioning Framework 2017-2025.

Evidence of effectiveness

The evidence base on self-management is substantial, but cannot answer all questions about how best to prioritise person-centred self-management. Issues to keep in mind include:

- More research has taken place on some interventions, such as structured education for self-management, than others, such as psychological support for people with long term physical health conditions.
- Few studies have followed up longer-term outcomes of interventions.
- Most research is from North America. We need to consider whether each study is generalisable to Cornwall.
- There is good evidence that some interventions make a difference, especially to patient-reported outcome measures (PROMs), but there is less evidence on cost-effectiveness.
- Evidence is lacking on how to ensure self-management of long term conditions reduces health inequalities and reaches those who find it hard to take part.

Evidence shows key components to enable self-management are:

- **Education for patients and carers**: condition-specific education in a variety of formats has been studied (group, individual, lay-led, online) but it is unclear whether any one format is most effective
- **Practical support**: for example treatment or medication adherence support and occupational and physiotherapy to help people with long term conditions cope with activities of daily living
- **Action planning** in conditions such as COPD where risk of deterioration is high
- **Psychological support**: helping people address changes to their 'normal' life and identity as a consequence of their long term condition
- **Social support**: the need for social support is a major issue, particularly in diabetes, stroke and dementia.
- **Healthy lifestyles:** taking steps toward healthy lifestyle changes including stopping smoking, keeping a healthy weight, and physical activity is key to managing LTCs well. Approaches that are informed by behaviour change theory are more likely to be effective.

Key Insights

- THERE IS NO 'ONE SIZE FITS ALL' APPROACH TO SELF-MANAGEMENT - IT IS IMPORTANT TO OFFER A RANGE OF OPTIONS AND FORMATS.

- MENTAL WELLBEING IS FUNDAMENTAL TO THE SELF-MANAGEMENT OF PHYSICAL CONDITIONS. SOCIAL AND EMOTIONAL SUPPORT CAN MAKE ALL THE DIFFERENCE

- DIGITAL FORMATS ARE LIKELY TO SUIT SOME PEOPLE MORE THAN OTHERS, AND SOME WILL NEED SUPPORT TO FEEL CONFIDENT IN USING NEW TECHNOLOGIES. NOT EVERYONE HAS ACCESS TO SMART PHONES/ COMPUTERS OR KNOWS HOW TO USE THEM.

- HEALTHY LIFESTYLES, SUCH AS BEING SMOKEFREE, HEALTHY EATING, HEALTHY WEIGHT, PHYSICAL ACTIVITY, AND REDUCING ALCOHOL, ARE ALL KEY TO GOOD SELF-MANAGEMENT, AND PEOPLE WOULD WELCOME MORE SUPPORT TO KEEP UP LIFESTYLE CHANGES.

- PEER AND SOCIAL SUPPORT IS REALLY IMPORTANT, BUT NOT EVERYONE IS COMFORTABLE IN GROUP SETTINGS

- FOR PEOPLE ON A LOW INCOME, HOMELESS OR SOCIALLY MARGINALISED, IT CAN BE HARD TO MAKE HEALTH AND WELLBEING A PRIORITY - MEETING BASIC NEEDS COME FIRST.

Current services, gaps and opportunities

- Self-management should go hand in hand with good quality clinical care. Improvement in LTC treatment locally could offer significant health benefits to individuals and quality and financial benefits to the system. For example, improving the number of people with diabetes who receive all nine recommended care processes. Pulmonary rehab provision and referral is lower in Cornwall than the national average. People are living longer with and beyond cancer, so need more support to help them manage their health and wellbeing after acute treatment ends. There are plans to offer people with cancer health and wellbeing assessments and opportunities through Cancer Transformation Funds.
- The voluntary and community sector are willing and able to provide peer, social and practical support, sometimes offered by national charities (e.g. Diabetes UK, Age UK). However further support and recognition is needed to increase their local capacity and sustainability long term. Social prescribing is one way to increase referrals to community support.
- Supporting people with LTCs to make healthy lifestyle changes by offering stop smoking, healthy weight and physical activity opportunities, could have an impact across a range of conditions. Help is available through Healthy Cornwall[9], but should also be embedded across LTC care pathways, or through health coaching models, such as Dorset's My Health My Way and the Cornwall Pharmacy Patient Activation Service.
- Some psychological/emotional support is offered through Outlook South West, the hospital clinical psychology service[10], and informally through voluntary and community sector and peer support groups. Pilots are underway in offering online Improving Access to Psychological Therapies (IAPT) and group support to people with LTCs. More focus on mental health and wellbeing of people with LTCs, both informal and formal, could have a multiplier effect on health outcomes by increasing people's capacity and motivation to self-manage their physical conditions.
- The Wanless Review suggests that 'for every £100 spent on encouraging self-care, around £150 worth of benefits can be delivered in return'.[11]
- Nesta estimates that providing four initiatives; peer support to people with mental health issues and coronary heart disease, and self-management education to people with cardiovascular disease and asthma, could offer a net savings of £2,100 to the health system per person per year.[12]

[9]Healthy Cornwall was formerly known as Cornwall and Isles of Scilly Health Promotion Service. More information is available at https://www.healthycornwall.org.uk/
[10]Limited to certain conditions.
[11]Wanless, D. (2002) Securing our Future Health: Taking a Long-Term View – The Wanless Review. London: HM Treasury.
[12]Nesta, Realising the Value: Impact and cost modelling tool for commissioners. London, Nesta. Available from: https://www.nesta.org.uk/report/impact-and-cost-economic-modelling-tool-for-commissioners/ [Accessed 23.08.2018].

CORNWALL SELF-MANAGEMENT MODEL

Strategic aims

The aim is for Cornwall to have a flourishing system of self-management support, and for people and communities to be empowered to take control of their health and wellbeing.

> "SELF MANAGEMENT SUPPORT SHOULD GO HAND IN HAND WITH GOOD QUALITY CLINICAL CARE."

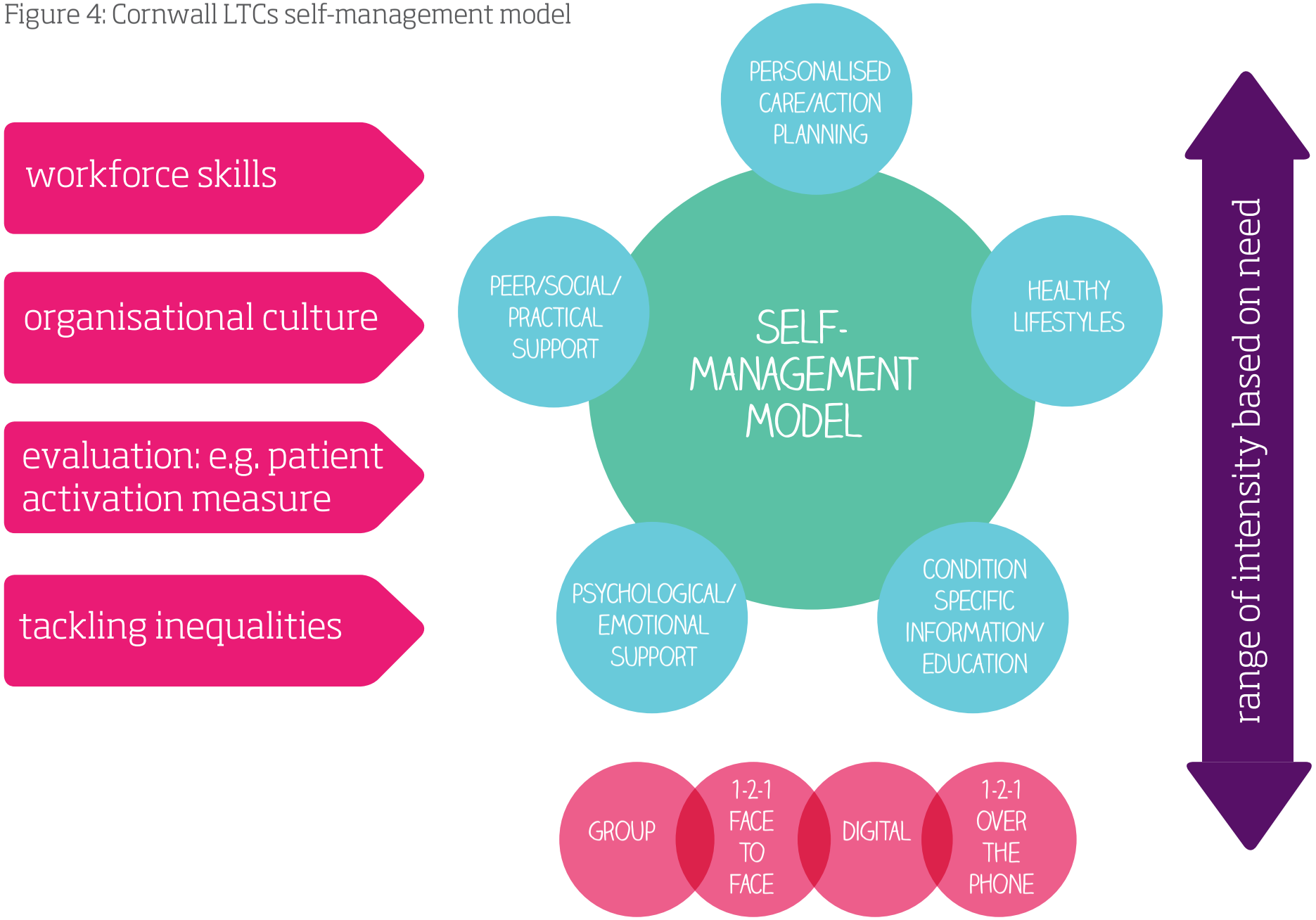
Design principles

Cornwall Self-Management Leadership Group agreed the following principles are important when developing self-management initiatives:

- Continue to move away from medical model to diagnose, treat, cure, to valuing self-care and self-management
- Build individual and community capability
- Further shift relationship between professionals and people to ensure decisions and conversations are equal and collaborative
- Person not system focused
- Consider people's different levels of readiness or activation
- Develop self-management in partnership with the person
- Mental health and wellbeing are integral to self-management of physical conditions
- Not one size fits all: provide a range of options and formats
- Test approaches on a few conditions/areas
- Increase people's access to their health data
- Address health inequalities and reach people who find it harder to engage in self-management opportunities

Figure 4 shows a model for self-management in Cornwall, based both on evidence and what matters to people locally, co-produced by the Cornwall Self-Management Leadership Group.

Figure 4: Cornwall LTCs self-management model



Personalised care/action planning

Engaging people in shared decision making process involving both goal setting and action planning. Plans should be written and owned by the person, but facilitated by a shared conversation with a professional. Online options including apps, e.g. mapmydiabetes, myCOPD, can support this approach but should not replace face to face contact and need to be carefully chosen and implemented. Targeted and opportunistic follow up in primary care can also enable this approach.

Condition specific information/education

Ranging from high quality, accessible information in a range of formats, provided at diagnosis and beyond, informal learning e.g. through peers, through to formal group learning, often known as structured education. May also be helpful to think of 'orientation' to the condition, at the point of diagnosis.

Healthy lifestyles

Support to help people make healthy lifestyle changes e.g. stop smoking, healthy weight, physical activity, alcohol.

Peer/social support

Peer support involves people sharing knowledge, experience or practical help. Many VCS groups encourage peer support. Peer support can take many forms, such as informal telephone calls, group meetings, online forums or structured training offered by paid peers in partnership with professionals. Wider social/practical support includes housing/employment/benefits advice, carer support, and social or interest groups such as arts and the natural environment. Referrral to these schemes is sometimes known as social prescribing.

Psychological/emotional support

Good mental wellbeing is integral to good self-management. People with LTCs can experience psychological and social challenges of their condition. Psychological support is important to prevent mental health problems, and can range from informal support from professionals/peers/family, to formal support from services such as Outlook South West and the Clinical Psychology Service.

Format

Self-management support should be provided in a range of formats to suit people's abilities and preferences:

- Group
- 1-2-1 face to face
- Digital
- 1-2-1 over phone

Organisational culture

Enabling self-management involves a cultural shift in how we understand the roles, responsibilities and relationship between people living with LTCs and the health and social care professionals and others who support them. It may mean conversations changing from "What's the matter with you?" To "What matters to you?" It can include outcomes-based commissioning, moving away from a system that focuses on payment for activity and instead focuses on commissioning outcomes that are meaningful to local people. When this is applied to commissioning self-management support, clinical outcomes are understood as contributory to the outcomes that are important to people – such as maintaining independence by staying active or in work. People generally need both clinical and non-clinical support to manage the different aspects of their conditions to achieve these broader outcomes. In practice, many outcomes-based commissioned contracts have relevant process measures, such as the number of people referred to a self-management programme or having a care plan[13].

[13]The Health Foundation (2016), A practical guide to self-management support: Key components for successful implementation. Available at: https://www.health.org.uk/publication/practical-guide-self-management-support [Accessed 23.08.2018].

Workforce skills

All practitioners can use the skills and approaches of self-management in their practice. For health professionals, it means not only providing clinical care, but helping people to think about their strengths and abilities, identifying their information needs and the changes they can make in their lives to take control, reach their goals and maintain their health and wellbeing.

Tools can include:

- Care and support planning
- Collaborative agenda setting
- Recognising and exploring patient activation levels/readiness to change
- Goal setting, action planning and follow-up

All of these approaches are underpinned by the use of core communication skills that build relationships of trust and rapport. These skills include: open-ended questioning; reflection; empathy; affirmation and normalisation; summarising; signposting; active listening and non-verbal communication. Further skills include health coaching approaches and helping people to explore the importance to them and their confidence of making changes.

Tackling inequalities

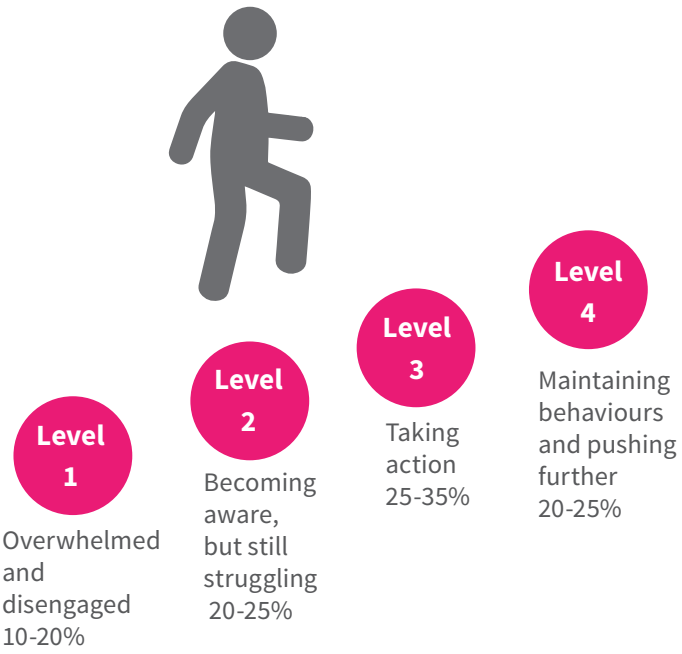
Nationally, self-management is often taken up by people who are already relatively well educated and say that they are in relatively good health. Local initiatives must make sure they reach and meet the needs of those from the most disadvantaged groups in Cornwall, who may face significant barriers to self-management.

Evaluation and outcomes

Various outcome measures can be used to show the impact of self-management. Not all outcomes can be expected for all conditions or types of support. Some outcomes are longer term than others, and depend on the duration and intensity of support given. Table 1 shows a range of outcomes and metrics that can be used to evaluate the impact of self-management.

One key self-management outcome measure is the **Patient Activation Measure (PAM)**, a validated tool to assess people's skills, knowledge and confidence and the extent to which people feel engaged and confident in managing their condition. People managing LTCs can be segmented into four activation levels (Figure 5). The proportion found in each segment has been found to be consistent across conditions and socioeconomic backgrounds. Supporting people to increase their activation level has been found to increase positive health behaviours, improve clinical outcomes and reduce healthcare costs.

Figure 5: Patient activation levels



Four activation levels along a continuum 0-100 point scale

A person's level of activation is dynamic, not a fixed label. The individual may have high levels of knowledge, skills and confidence, and so be highly activated. However, if they then receive a new diagnosis or experience a new complication, their level of knowledge, skills and confidence may decrease, until they have developed the knowledge, skills and confidence to manage it well. A person may also think they are knowledgeable about their condition, but taking part in an intervention makes them realise they knew less than they thought, so their score may decrease temporarily as a result.

Other measures are available and should be used as appropriate.

Table 1: Potential outcome measures for evaluating self-management

Type of impact	Measurable outcome	Suggested metrics for measuring
Financial	Non-elective admissions	Number of unplanned admissions for key conditions
	Avoidable admissions	Number of admissions for ambulatory care sensitive conditions
	In-patient admissions	Number of hospital admissions in 1 year
	Service usage	% of people who reported a reduction in use of primary and secondary health services
	Appointments	Total outpatient appointments/GP appointments
	Readmissions	Number of readmissions to hospital
	A&E visits	Mean A&E visits in past 3 months/year
	Length of stay	Reduction in length of stay per individual admitted
Health and wellbeing	Patient activation	% patients with a meaningful improvement in Patient Activation Measure (PAM) scores
	Specific health measures	Reduction in HbA1C level (diabetes); medication adherence; improvement in blood pressure mmHG (CVD); % reduction in CHD events (over 10 years)
	Smoking	% of individuals reporting to have quit smoking after the programme
	Body Mass Index and BMI	% of individuals reporting a reduction in weight of at least 5%; BMI reduction
	Exercise	Time spent on exercise in previous seven days (mean in minutes)
	Anxiety and depression	% of people who reported a reduction in anxiety/ depression/geriatric depression scale
Wider Social	Social connectedness	% more confident in groups; % reporting improvement in close relationships
	Individual wellbeing	% being better able to cope with life's challenges/more in control of their lives
	Confidence/self-worth	% of people reporting that they felt more confident after the approach
	Employment	% of people who reported acquisition of work skills that led to employment
	Financial prospects	% of people who reported improved financial prospects following approach
	Volunteering	% undertaking development of formal/informal skills through volunteering
	Work attendance	Work days missed in past 30 days/year
	Self-management	% reporting ability to self-manage their health more effectively
	Alcohol and drug use	% of people who reported a reduction in rates of substance misuse/alcohol consumption

Strategic Objectives

The following strategic objectives are recommended to build a system that supports self-management in Cornwall. An indicative assessment of the current situation is made using the following:

Green: plans are in place, resources allocated
Orange: some activity/resource exists but more should be developed
Red: high priority

1 Organisational culture, planning, communication and co-production

1.1 Continue to facilitate Self-management Leadership Group and wider engagement.

1.2 Develop rolling communications and engagement plan to raise awareness of self-management support among staff and public.

1.3 Identify opportunities for funding and develop business cases for further self-management support.

2 Workforce skills and development

2.1 Embed self-management and personalised care into staff communication and training, including approaches such as Making Every Contact Count and health coaching.

2.2 Increase capacity for LTC self-management support in primary care.

3 Personalised care/action planning

a. Develop personalised care plan under Shaping Our Future including elements from the self-management model.

b. Ensure digital support is carefully curated and coordinated across the system. Ensure resources are available to support initial and ongoing implementation and evaluation of digital support.

c. Roll out new Telehealth service including increased self-management support.

d. Use data and technology to identify and recall patients at risk.

4. Condition-specific information/Education*

4.1 Review information currently provided, including content, reach and impact.

4.2 Evaluate use of patient information videos through primary care.

4.3 Develop and evaluate diabetes structured education.

4.4 Increase capacity in pulmonary rehab through system-wide pathway improvement. Pilot myCOPD as digital alternative.

4.5 Increase support for people living with and beyond cancer with holistic needs assessment and care plan, and access to self-management support through health and wellbeing/self-management events courses.

4.6 Explore use of a range of cardiac rehabilitation formats e.g. Heart Manual to extend reach.

5. Healthy lifestyles

5.1 Develop physical activity opportunities suitable for people with various LTCs, ensure they are targeted to people who can most benefit from them.

5.2 Build strong links between community exercise providers (e.g. Healthy Cornwall or leisure providers) and primary and secondary services and ensure they are suitably qualified to provide exercise for people with LTCs.

5.3 Ensure referral to stop smoking services is a core element of care pathways for people with LTCs.

6. Peer/social/practical support

6.1 Ensure GP practices routinely signpost people to local peer, social and practical community support, either through social prescribing routes or local arrangements.

6.2 Include clear links to LTC support groups through the Cornwall Social Prescribing programme.

6.3 Develop community information and signposting e.g. Cornwall Link, Support in Cornwall websites.

6.4 Develop capacity and resources in VCS to provide self-management support across Cornwall. Consider providing peer support groups. that are open to supporting people with co-morbidities or similar symptoms – e.g. breathlessness, centipede clubs.

6.5 Review and develop practical support available – e.g. housing, winter wellbeing (using the Cold Homes Toolkit) and benefits advice.

[15]Behavioural Insights Team (201 EAST: Four Simple Ways to Apply Behavioural Insights. Available at: https://www.behaviouralinsights.co.uk/publications/east-four-simple-ways-to-apply-behavioural-insights/

7. Mental wellbeing

7.1 Embed awareness and support for mental wellbeing of people with LTCs into routine physical care e.g. routine assessment.

7.2 Offer training and support to VCS around mental health and wellbeing.

7.3 Pilot and roll out psychological support for LTCs e.g. IAPT Silvercloud, group support.

8. Evaluation

8.1 Evaluate new and existing programmes using self-management measures such as the PAM and relevant clinical/health-related quality of life measures.

9. Tackling inequalities

9.1 Address social as well as health needs.

9.2 Target and tailor support and services to areas of high need.

*Examples are provided for the conditions that have been used as examples throughout the self-management workstream so far. These objectives are not exhaustive and further work should take place in the future to ensure condition-specific self-management support is available across conditions.

Models of change and ways of working

Self-management is not always easy. It involves people – and professionals – making changes, creating new habits, mastering new information and techniques and letting go of old unhelpful behaviours. 'Behavioural science' can help us understand what makes it easier or harder for individuals and groups to make changes.

EAST

The EAST framework was developed as a simple tool to help people and practitioners start thinking about the enablers and barriers to behaviour change.[15] To encourage a particular behaviour, make it Easy, Attractive, Social and Timely (EAST):

- Make it Easy: Small, seemingly irrelevant, details that make a task more challenging or effortful can make the difference between doing something and putting it off – sometimes indefinitely.
- Make it Attractive: Attracting attention and incentivising behaviour are important for prompting people to behave in a new way and maintain behaviour change.
- Make it Social: People are social creatures; we are influenced by what those around us do and say, often more than we are consciously aware of.
- Make it Timely: The same offer or 'prompt' to change behaviour made at different times can have different effects.

Figure 6 shows how this can apply to enabling self-management.

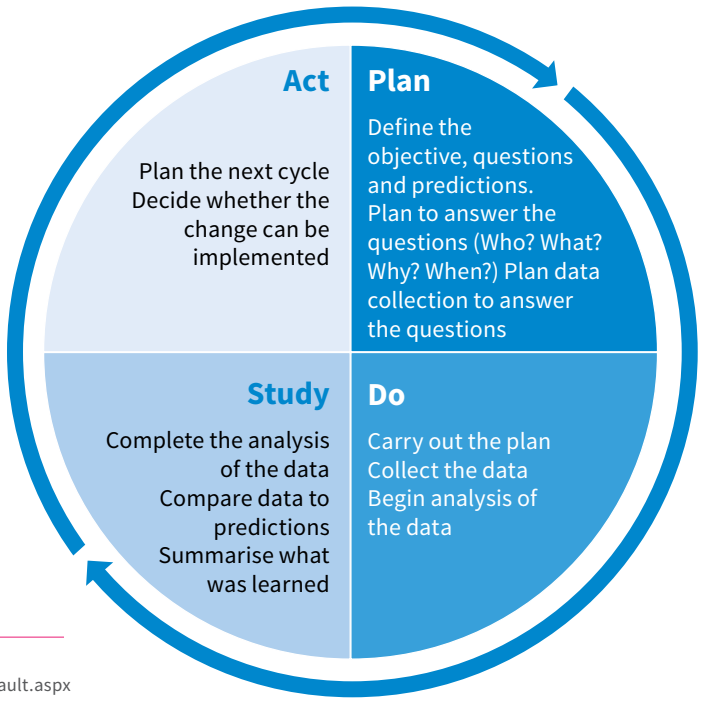
Figure 6: Making self-management Easy, Attractive, Social and Timely (EAST)

Source: NESTA, Supporting Self-management. https://media.nesta.org.uk/documents/rtv-supporting-self-management.pdf

PDSA

The Plan, Do, Study, Act (PDSA) cycle can be used to guide organisational change and encourage continuous improvement, and has been adopted by Shaping Our Future as a way to test new ways of working across the system (Figure 7).

Figure 7: PDSA Cycle[16]



[16]http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Implementation options

There are a number of options for how self-management is progressed in Cornwall, depending on the resources and capacity available.

1. **Implement individual components:** 'Test and learn' the whole self-management components across Cornwall, within mainstream resources and mechanisms such as Shaping Our Future pathway workstreams. e.g. rolling out structured education, IAPT for LTCs, peer groups, Telehealth, myCOPD.
2. **Implement whole model, place-based, but separate services:** 'Test and learn' whole self-management model in one locality/ cluster/practice to evaluate the impact of providing comprehensive support for people with LTCs. Components delivered by separate organisations.
3. **Develop business case for whole model, countywide self-management service, delivered by one organisation/consortium.** See, for example, My Health My Way LTC condition self-management service, Dorset (Appendix 1).

The Self-Management Leadership Group has demonstrated the benefits of partnership working and co-production. All options require continued partnership working across the system including:

- Primary care
- Secondary care
- Pharmacy
- Voluntary and community sector including peer groups and patient reps
- Healthy lifestyle services
- Mental health services
- Adult social care

"SELF MANAGEMENT SUPPORT IS NOT ONE SINGLE APPROACH. IT CANNOT BE PRESCRIBED OR PUT IN A PACKAGE, LIKE A MEDICINE. IT IS A CULTURE SHIFT."

APPENDIX 1

MY HEALTH, MY WAY: AN EXAMPLE OF A COMPREHENSIVE SELF-MANAGEMENT SERVICE FOR PEOPLE WITH LTCs

Launched in November 2013, My Health My Way (MHMW) is a comprehensive non-clinical self-management programme open to anyone with a LTC living in Dorset. MHMW aims to target people of a lower health literacy who are less activated, as well as younger people (aged 30-45 years old) in work, people from Dorset's rural communities and people without access to a computer.

Clients can self-refer, or be referred via a clinician or community service. They are directed to a central gateway team who provide basic information about the service and assess whether the client wants to continue. Clients are then directed either to the Know Your Own Health (KNOH) web-portal, containing local information and an online assessment, or directly to health coaches. Health coaches exlpore the client's needs and goals, and then together they decide which of the following support methods would best suit them:

- **One-to-one health coaching**, which provides face-to-face, telephone and e-mail support for up to six sessions. Coaching is based on motivational interviewing;
- **Face-to-face group courses**, where clients receive a self-management handbook and take part in courses covering a range of topics (e.g. frustration, fatigue, pain and isolation; appropriate use of medication; communicating effectively with family, friends and health professionals);
- **Peer support groups**, which meet face-to-face and are designed to support clients following the end of one-to-one health coaching or face-to-face group courses.

- **Information and signposting** is supported by an online platform and is designed to be used both alongside other forms of support (e.g. coaching and group courses)
- **Online self-management support** allows clients to access the KYOH patients eLearning programme. This is a six week course covering concepts of self-care and health and wellbeing, that can be facilitated by a health coach or can be carried out by the client on their own;
- **Online peer support**, provide a space in the form of an online forum for people to discuss issues that are relevant to them with people who may be in a similar situation;
- **Carers** of clients are also able to access all of the information available on the KYOH web-portal.
- Although there was limited data to provide information about other aspects of client backgrounds, **analysis of available data indicates that MHMW appears to be successful at attracting clients from 'hard to reach groups',** e.g. clients with lower levels of education, those with low incomes and the unemployed – 80% of those responding to income-related questions reported a household income of under £15,000.
- **Clients reported a wide range of health conditions, including some reporting multiple morbidities.** Musculoskeletal conditions were the most commonly reported primary condition, affecting a quarter of clients. Fibromyalgia, diabetes and heart disease also affect a high proportion of clients.

- **Clients favoured one-to-one support (via face-to-face sessions or telephone).** Some clients also accessed multiple forms of support, suggesting that clients were comfortable moving between the different types of support or were actively encouraged to do so.

Analysis of HEI-Q scores (a self-management measure) indicates that there were statistically significant improvements between baseline and follow up scores reported by clients for all domains.

The average PAM score of the client population at the baseline level was 48.2 and the average score at the follow up level was 53.7, representing an average increase in PAM score of 5.5. A robust cost analysis was not possible, but illustrative client case studies demonstrate that MHMW is potentially cost-saving.

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Falmouth University
Healthwatch Cornwall
Healthy Cornwall
Liskeard and South East Cornwall Breathers
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Newquay Happy Hearts
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The Patient's Association

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