Health and Wellbeing Board
Hertfordshire

Agenda Item No.

5

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
THURSDAY, 2 MARCH 2017 AT 10.00AM

SELF-MANAGEMENT STRATEGY

Report of:

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1.0 Purpose of report

1.1 The purpose of this Report is to bring the Self-management Strategy to the attention of the Health and Wellbeing board.

2.0 Summary

2.1 Long term conditions (LTCs) are illnesses with no cure and management of these conditions are aimed at controlling the symptoms. There is a huge range of conditions that are considered LTCs, but these can include diabetes, chronic obstructive pulmonary disease (COPD), mental health conditions, rheumatoid arthritis, HIV and cancers. Currently, long term conditions (LTCs) affect 15 million people in the UK, and an estimated 318,000 in Hertfordshire. By 2025, there will be an estimated 18 million people with LTCs in the UK. Many people are living with multiple LTCs as 24% of patients have two LTCs and 20% have 3 or more.

2.2 People with LTCs are frequent users of the healthcare system with 55% of GP appointments and 68% of outpatient and A&E appointments are due to LTCs. The financial pressures from LTCs are estimated to cost £5 billion a year between 2011 and 2018.

2.3 LTCs also have heavy implications for adult social care. The impact of poor medical management of an individual's LTC does not only impact the healthcare services, but also social care.

2.4 It is also important to note that LTCs have further reaching affects, such as on the wider community and economy as having a debilitating condition can affect an individual's ability to contribute to society.

2.5 Self-management can be used to support patients with LTCs. It is where a person with LTCs can take ownership for their own health and wellbeing. This can include physical or mental health, preventing accidents or health conditions, managing for minor health problems or LTCs and ensuring a good level of health after recovering from an illness or hospital admission.

2.6 Self-management is not a specific action, treatment or service, but involves health and social care professionals, patients, carers and families working in collaboration towards a shared tailored management plan based on the patient's specific set of circumstances. These circumstances could depend on their medical conditions, health literacy, social and local support and confidence. For example, the social costs of managing people with dementia is estimated to cost £2.13 billion annually whilst Diabetes UK estimates diabetes care as costing adult social care £830 million per year, and these figures will rise with the increasing numbers of people living with LTCs and multi-morbidities.

2.7 The self-management strategy will help to ensure the delivery of prevention services across Hertfordshire using self-management principles. Led by the Self-management steering group, this strategy will ensure the services for patients with LTCs are aligned across all providers and commissioners, including both CCGs across Hertfordshire (Herts Valleys and East and North Herts CCGs).

3.0 Recommendation

3.1 The Health and Wellbeing Board is asked to:

- Note the contents of the report and endorse the Self-Management Strategy.

4.0 Background

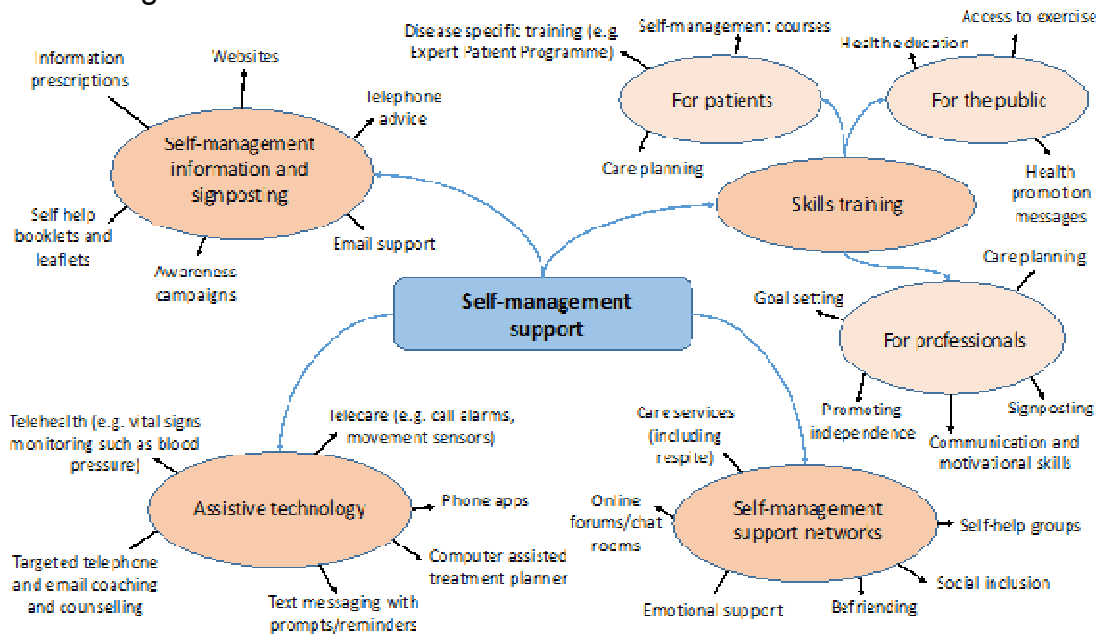
4.1 What is self-management?

Self-management is where a person with LTCs takes ownership for their own health and wellbeing. Self-management gives them the tools and confidence to do so. This can include physical or mental health, preventing accidents or health conditions, managing for minor health problems or LTCs and ensuring a good level of health after recovering from an illness or hospital admission.

Self-management is not a specific action, treatment or service, but involves health and social care professionals, patients, carers and families working in collaboration towards a shared tailored management plan based on the patient's specific set of circumstances. These circumstances could depend on their medical conditions, health literacy, social and local support and

confidence.

There are a multitude of ways that self-management can be supported. These are shown in figure 1.



4.2 Benefits of self-management

The grey (unpublished) and published literature has shown that self-management is linked to a reduction in health service utilisation, improved clinical outcomes for patients, improved patient experience and confidence in managing their own conditions and improved quality of life. There was also evidence of increased job satisfaction amongst healthcare professionals and a streamlining of services. However, there was mixed evidence of the cost effectiveness of self-management services, but this is difficult to evaluate accurately. For elderly patients discharged from hospital, there is evidence that successful discharge to independent settings rather than institutional care translate to savings in social care and the NHS. Even though there is limited evidence of social care benefits, it is very likely that using self-management principles will also lead to savings in adult social care.

Self-management links with and will help achieve existing national and Hertfordshire-wide priorities, including the Five Year Forward view nationally,

and Hertfordshire's Health and Wellbeing Board and Sustainability and Transformation Plan (STP) priorities.

There are services present in Hertfordshire which have a focus on self-management. However, these services are not currently coordinated across providers and commissioners and there is no comprehensive list of which services are available in Hertfordshire.

4.3 Self-management strategy

4.3.1 Aim of strategy

This strategy (Appendix 1) is aimed at all commissioners, providers, health and social care professionals, the voluntary sector and communities who are involved with services for patients with long-term conditions across Hertfordshire.

Our aim is to improve the health and wellbeing of Hertfordshire's population by embedding the principles of self-management across the health and social care system.

In particular, this current strategy will target the population with LTCs.

4.3.2 Principles of self-management

The aims of the strategy are supported by six key principles of self-management, which are listed below. These will be adopted into all existing and newly commissioned services for patients with long term conditions.

- Develop a culture of supporting self-management amongst the Hertfordshire population and all who work with patients with long term conditions, which is led by effective and strong clinical leadership.
- Provide a collaborative, integrated and personalised approach to self-management services to support all and encourage shared decision making.
- Use a whole system approach to implementing and commissioning services.
- Ensure information regarding self-management services is widely promoted and easily accessible.
- Establish consistent and effective support of the workforce.
- Regular evaluation which is feasible and with active improvement of services.

4.3.3 Strategy implementation

The implementation of the strategy will be over a 3 year period (2017-2020). Examples of how each principle of the strategy will be delivered are outlined in the Strategy Implementation table (Appendix 2).

5. Financial implications

No additional Public Health funding is required to deliver the strategy.

Report signed off by	Public Health and Localism and Libraries cabinet panel, HVCCG Commissioning Executive and ENHCCG development group
Sponsoring HWB Member/s	Jim McManus, Consultant in Public Health
Hertfordshire HWB Strategy priorities supported by this report	Identify which priority/ies: 1. Focus on preventive approaches – helping people and communities to support each other and prevent problems from occurring for individual and families in the future 2. Always consider what we can do better together – focusing our efforts on adding value as partners to maximise the benefits for the public 3. Encourage opportunities to integrate our services to improve outcomes and value for taxpayers.
Needs assessment (activity taken) This strategy supports the health needs assessment undertaken by Herts County Council Public Health department for people with long term conditions, it also supports the prevention priorities of the local STP and the strategic shift of 40% of outpatient appointments to the community.	
Consultation/public involvement (activity taken or planned) The following stakeholders have been consulted: Public health consultants and director of public health at Hertfordshire County Council Herts Valley CCG East and North Herts CCG Patient groups Public Health, Localism and Libraries Cabinet Panel, Hertfordshire County Council Integrated Health and Care Commissioning Team Health improvement team, Hertfordshire County Council Health and Community Services, Hertfordshire County Council Hertfordshire Community NHS Trust Integrated Care Programme Team, Hertfordshire County Council Public health officers at Hertfordshire County Council Patient focus groups for COPD and diabetes Watford and Three Rivers patient event	
Equality and diversity implications Equality Impact Assessment (Appendix 3)	

Acronyms or terms used. eg:	
Initials	In full
CCG	Clinical commissioning groups
LTCs	Long term conditions
A&E	Accident and emergency
STP	Sustainability and Transformation Plan
COPD	chronic obstructive pulmonary disease

Appendix 1:
Hertfordshire Self-management Strategy

Hertfordshire's Self-management Strategy 2017-2020

Contents

Executive summary

The consequences of LTCs

Long term conditions (LTCs) are illnesses with no cure and management of these conditions are aimed at controlling the symptoms. There is a huge range of conditions that are considered LTCs, but these can include diabetes, chronic obstructive pulmonary disease (COPD), mental health conditions, rheumatoid arthritis, HIV and cancers. Currently, long term conditions (LTCs) affect 15 million people in the UK, and an estimated 318,000 in Hertfordshire. By 2025, there will be an estimated 18 million people with LTCs in the UK. Many people are living with multiple LTCs as 24% of patients have two LTCs and 20% have 3 or more.

People with LTCs are frequent users of the healthcare system with 55% of GP appointments and 68% of outpatient and A&E appointments are due to LTCs. The financial pressures from LTCs are estimated to cost £5 billion a year between 2011 and 2018.

Children are also affected by long term conditions, with 23% of 11-15 year olds reporting being diagnosed with a long-term illness, disability or medical condition.

LTCs also have heavy implications for adult social care. The impact of poor medical management of an individual's LTC does not only impact the healthcare services, but also social care. For example, the social costs of managing people with dementia is estimated to cost £2.13 billion annually and Diabetes UK estimating diabetes care costing adult social care £830 million per year and these figures will rise with the increasing numbers of people living with LTCs and multi-morbidities.

It is also important to note that LTCs have further reaching affects, such as on the wider community and economy as having a debilitating condition can affect an individual's ability to contribute to society.

What is self-management?

Self-management is where a person with LTCs can take ownership for their own health and wellbeing. This can include physical or mental health, preventing accidents or health conditions, managing for minor health problems or LTCs and ensuring a good level of health after recovering from an illness or hospital admission.

Self-management is not a specific action, treatment or service, but involves health and social care professionals, patients, carers and families working in collaboration towards a shared tailored management plan based on the patient's specific set of circumstances. These circumstances could depend on their medical conditions, health literacy, social and local support and confidence.

Improving both medical and social care are linked to improved patient outcomes. Using self-management principles in a social care setting can help improve a patient's compliance and ability to follow medical management plans. For example, if a diabetic patient's social care needs of accommodation are met, they may be more able and motivated to focus on optimising the management of their diabetes.

Support from the health and social care services is required to ensure the correct training and environment is available to accommodate this. Self-management principles can also be supported by an individual's social network.

Examples of self-management support are shown in figure 1 below.

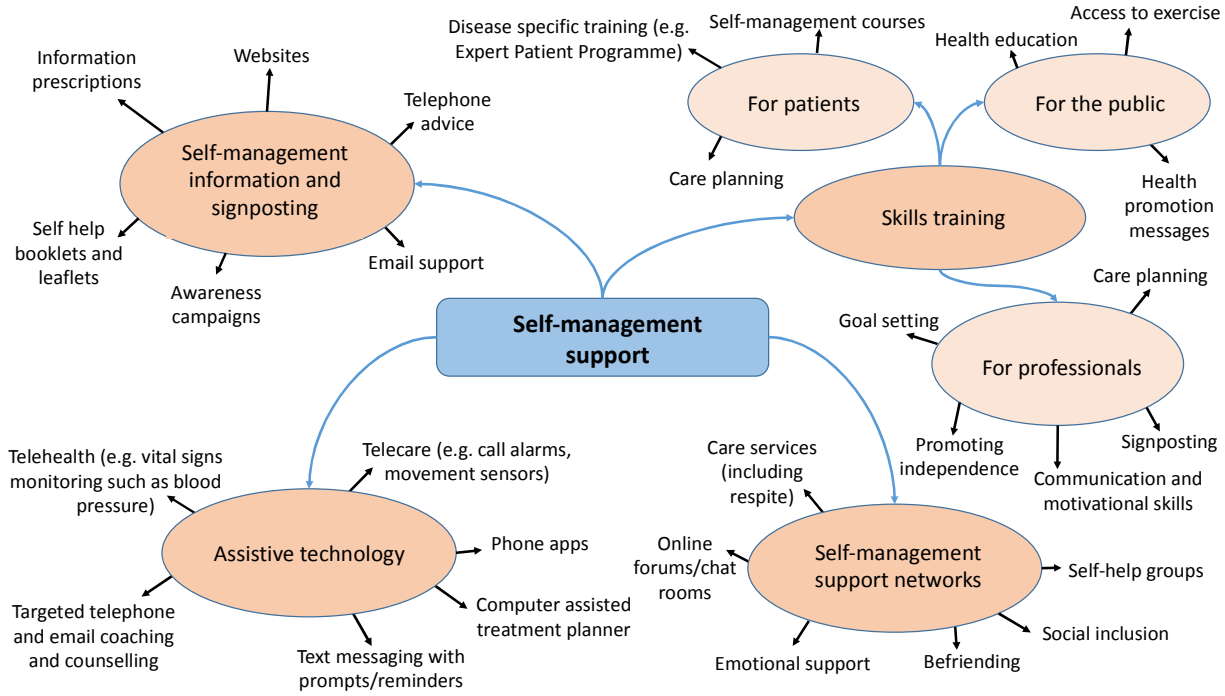


Figure 1 Self-management support (adapted from Improving Health and Wellbeing in Wales, a Framework for Supported Self Care, Welsh Assembly Government, October 2009

Benefits of self-management

There is evidence in the literature (grey and published) that there is a reduction in health service utilisation, improved clinical outcomes for patients, improved patient experience and confidence in managing their own conditions and improved quality of life. There was also evidence of increased job satisfaction amongst healthcare professionals and a streamlining of services. However, there was mixed evidence of the cost effectiveness of self-management services, but this is difficult to evaluate accurately. For elderly patients discharged from hospital, there is evidence that successful discharge to independent settings rather than institutional care translate to savings in social care and the NHS. Even though there is limited evidence of social care benefits, it is very likely that using self-management principles will also lead to savings in adult social care.

Self-management and existing national and local priorities

Self-management links with and will help achieve existing national and Hertfordshire-wide priorities, including the Five Year Forward view nationally, and Hertfordshire's Health and Wellbeing Board and Sustainability and Transformation Plan priorities.

Current self-management services in Hertfordshire

There are services present in Hertfordshire which have a focus on self-management. However, these services are not currently coordinated across providers and commissioners and there is no comprehensive list of which services are available in Hertfordshire.

Aim of strategy

This strategy is aimed at all commissioners, providers, health and social care professionals, the voluntary sector and communities who are involved with services for patients with long-term conditions across Hertfordshire.

Our aim is to improve the health and wellbeing of Hertfordshire's population by embedding the principles of self-management across the health and social care system.

In particular, this current strategy will target the population with LTCs.

Principles of self-management

These aims will be achieved by the ensuring the principles of self-management, listed below, are adopted into all existing and new commissioned services for long term conditions.

1. Develop a culture of supporting self-management amongst the Hertfordshire population and all who work with patients with long term conditions, which is led by effective and strong clinical leadership.
2. Provide a collaborative, integrated and personalised approach to self-management services to support all and encourage shared decision making.
3. Use a whole system approach to implementing and commissioning services.
4. Ensure information regarding self-management services is widely promoted and easily accessible.
5. Establish consistent and effective support of the workforce.
6. Regular evaluation which is feasible and with active improvement of services.

Strategy Implementation

This strategy is currently planned to be implemented over the next 3 years (2017-2020). The Strategy Implementation table outlines how each principle of the self-management strategy can be delivered in each year. This is discussed in section 8 of this document.

1. Introduction

Currently, long term conditions (LTCs) affect 15 million people in the UK, and an estimated 318,000 in Hertfordshire (1; 2). By 2025, there will be an estimated 18 million people with LTCs in the UK (2).

According to the Department of Health, LTCs are illnesses that cannot be cured, but the symptoms can be controlled with medical treatment (3). There is a huge range of diseases considered to be LTC, but there is no definitive list. They include cardiovascular and respiratory diseases, diabetes, musculoskeletal conditions and mental illnesses. HIV and cancer are also considered LTCs (4).

Across the country, 55% of GP appointments and 68% of outpatient and A&E appointments are due to LTC. The financial pressures from LTCs are estimated to cost £5 billion a year between 2011 and 2018 (2).

Children are also affected by long term conditions. This can include asthma, diabetes, cancer, epilepsy and other mental and physical disabilities. In 2014, a survey of English school children aged 11-15 found 23% reported having a LTC or disability. Of these, 24% admitted that their medical problem or disability affected their school life (6).

For patients with long term conditions, there is evidence that self-management may be able to improve clinical outcomes (physical, psychological and social wellbeing), overall patient experience and decrease the effects of long-term conditions on the healthcare system.

It is also important to note that many of these people with LTCs may also have more than one condition. 24% have two LTCs and 20% have 3 or more (5). Prevalence of mental health conditions in people who have other LTCs are 2-3 times people who do not, and of the NHS expenditure spent on LTCs, 12-18% can be attributed to poor mental health and wellbeing (23).

LTCs also have heavy implications for adult social care. For example, the social costs of managing people with dementia is estimated to cost £2.13 billion annually and Diabetes UK estimating diabetes care costing adult social care £830 million per year and these figures will rise with the increasing numbers of patients living with LTCs and multi-morbidities (7; 8).

Improving both medical and social care are linked to improved patient outcomes. Using self-management principles in a social care setting can help improve a patient's compliance and ability to follow medical management plans. For example, if a patient with a long term mental health condition, such as depression, has their social care needs of accommodation met, they may be more able and motivated to focus on optimising the management of their depression.

2. What is self-management?

2.1 Definition of self-management

Self-management has been defined locally as "the formation of a collaborative relationship between the patient and the clinician which, through the use of a variety of techniques and tools, enables the patient to manage their health as effectively as possible."

Self-management is where a person takes ownership for their own health and wellbeing. This can include physical or mental health, preventing accidents or health conditions, managing for minor health problems or LTCs and ensuring a good level of health after recovering from an illness or hospital admission (9).

In this strategy, self-management refers in particular to patients with LTCs.

Self-management is not a specific action, treatment or service. It requires that all individuals and services involved in the care or social needs of a particular person work together to empower that individual by using a person-centred, collaborative approach to problem solving (10). This would be in conjunction with carers and families. The approach can include learning and using specific techniques or skills with varying levels of support dependant on the needs of the individual's condition, life stage and confidence in their ability (10). This also extends to a carer's or family's confidence in managing their client or relative's condition. To maximise effectiveness, self-management also considers other inequalities or barriers that could affect a person's self-management abilities, for example health literacy, intelligence, socioeconomic status, gender and ethnicity.

This type of approach towards patient-centred care involves a clinician building an effective rapport with the patient by using active listening to a patient's needs and capabilities and then setting meaningful goals for the patient. By working in this way, the treatments may be more effective and patients may be more compliant and feel more of a sense of responsibility towards their health and changing their behaviour.

In the existing literature on self-management, there is no universally accepted definition of self-management and it has been acknowledged that it can mean "different things to different people" (11; 12).

2.2 Self-management vs self-care

Self-care and self-management are terms that are often used interchangeably. Self-management is used to refer to long term conditions, whereas self-care can be generalised to all actions to sustain health and wellbeing (13).

According to the Health Foundation, self-management is part of "person-centred care", which is made up of 4 concepts (12; 14):

- Being treated with dignity, compassion and respect
- Ensuring care, support or treatment is co-ordinated
- Ensuring care, support or treatment is personalised
- Ensuring care, support or treatment enables an independent and fulfuiling life.

2.3 Self-management and long term conditions

For people with LTCs, self-management can help improve collaboration with them, so that health and social care professionals can work as a partnership to reach outcomes that are important to that particular person.

The Health Foundation, an independent UK healthcare charity, commissioned a report which described how self-management can help patients with LTCs to gain "knowledge, skills, confidence and resilience to manage the impact of their symptoms and limitations so they can live a full and meaningful life", which has a positive impact on their health and mental and social wellbeing (14).

2.4 The House of Care

The House of Care was originally developed for diabetes for the Year of Care partnership. It has since been adapted and applied for patients with all types of LTCs and now has an emphasis on active patient involvement. It is a "co-ordinated service delivery model" which aims to provide care which is "proactive, holistic, preventive and patient-centred" (15).

The four facets of this approach are shown in the figure 2 below. This diagram is used to demonstrate how inter-connected and dependent each facet is to the whole model.

The House of Care provides a foundation on which Hertfordshire's Self-Management strategy can be built upon.

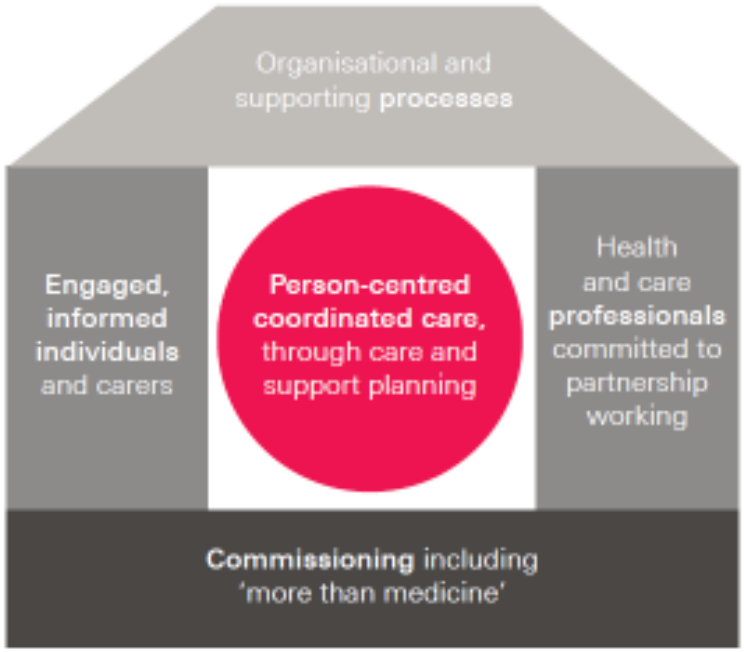


Figure 2 The House of Care Model (15)

2.5 How self-management skills and knowledge can be delivered

Figure 3 summarises the different methods that self-management support can be delivered to patients, the public and professionals, and how information, sign posting, technology and support networks can be used to help people self-manage their health conditions. See section 7.2 for further discussion with examples of many of these methods.

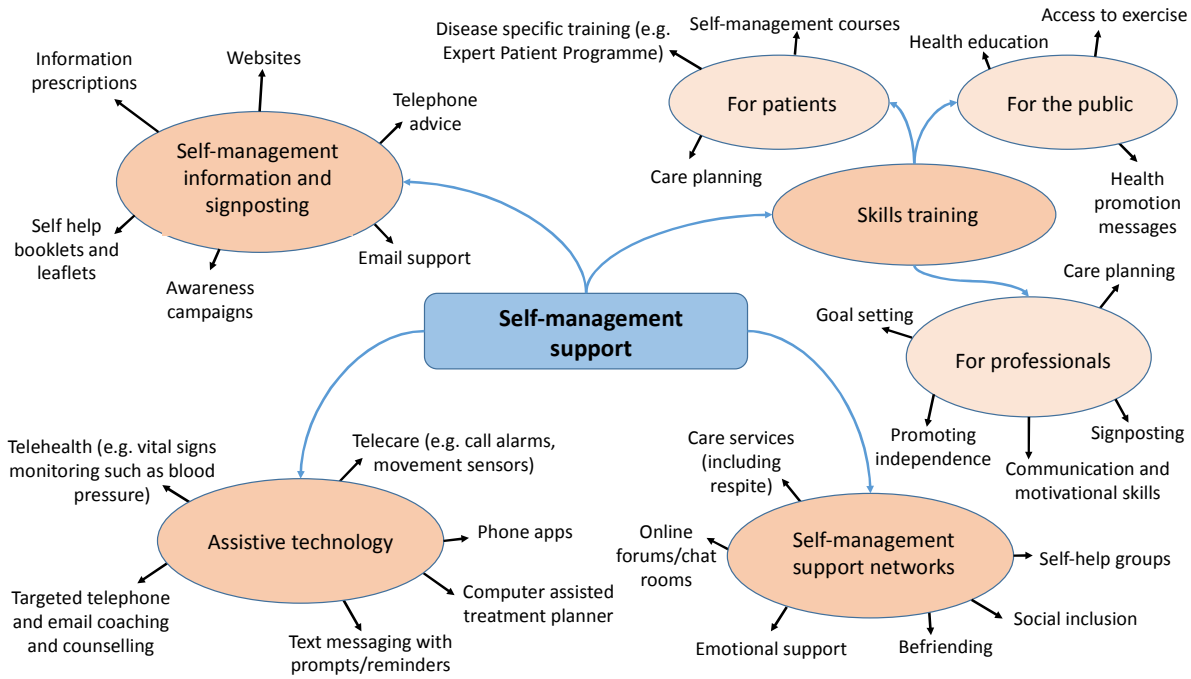


Figure 3 Self-management support (adapted from Improving Health and Wellbeing in Wales, a Framework for Supported Self Care, Welsh Assembly Government) (16)

3. Public health benefits of self-management

There is evidence that a self-management approach improves many facets of healthcare and although there is no directly supporting evidence, it is likely that social care will also benefit. Improvement in health care outcomes range from the clinical outcomes of patients, increased satisfaction of patients and healthcare professionals to improved streamlining of services.

The evidence described here is derived from reviews of reviews or evaluations of services for adults with LTCs (14; 17; 18; 19; 20; 21).

3.1 Population and patients:

Reduction health service utilisation

A few studies showed a reduction in general hospital use and one study showed evidence that self-management programmes were able to reduce emergency admissions for COPD and asthma (17).

Disease-specific group education, in particular, asthma self-management courses had the most evidence of improving service use (19).

Improved clinical outcomes

A few reviews reported patients' clinical outcomes for long term conditions had improved (14; 21). One study found an increase in patients' physical capabilities and an improved compliance with treatment (21).

The National Voices review of systematic reviews found that group-based self-management education, online education, telehealth and self-monitoring had the most evidence supporting improved health outcomes (19).

Improved experience and engagement

Patients and carers had an improved experience with the health service and showed improved confidence with managing long term conditions and reduced anxiety (14; 21).

Improve knowledge and health education

Amongst the different self-management approaches, one review of systematic reviews found that group-based self-management education had the most supportive evidence to improve knowledge (19).

Better quality of life

There is also evidence that self-management can help improve anxiety and depression which is commonly associated with long term conditions (19).

A review by the University of York and De Iongh found evidence that self-management techniques improved quality of life reported by patients. In particular, the University of York concluded that patients with long term conditions had short term improvements with quality of life, but with a small effect size. There is also unfortunately little evidence with regards to multiple comorbidities (17).

Social care

There is evidence from qualitative studies that patients believe there is a need for more social care support with LTCs such as stroke and diabetes (19; 22).

There is evidence that social groups for those with stroke or diabetes, which could be provided by social care can help develop social networks and "allies" between people with the same LTCs, and increase their confidence and psychological wellbeing (22).

There is a gap in the existing literature on specific social care benefits from self-management. However, it stands to reason that using self-management principles within social care may lead to improved patient outcomes.

3.2 Healthcare professionals

Increased job satisfaction

There was evidence of increased job satisfaction from healthcare professionals in the UK as they were supported to offer self-management type consultations with patients. Their satisfaction was derived from patients benefiting more from these types of consultations (14).

3.3 Healthcare services

Streamlining of services

De Iongh et al found that the organisational changes required to provide a self-management orientated service led to the services offered being more "joined-up" and cost effective (14).

Cost effectiveness

There was conflicting evidence with regards to cost-effectiveness of self-management services. There is the potential to reduce costs due to the reduction in utilisation of health services such as GP and outpatient

appointments, hospital admissions and inpatient stays (19). In particular, self-management initiatives to improve education and communication in diabetes and self-monitoring of oral anticoagulants have been evaluated and costs savings found. Other evaluations, such as support for elderly patients with chronic pain did not find savings compared to usual care. However, there may be wider reaching benefits related to costs which are difficult to measure (17; 21).

From a social care point of view, for elderly patients discharged from hospital, there is evidence that successful discharge to independent settings rather than institutional care translate to savings in social care as well as the NHS (23).

One paper noted that extensive assessments of the cost benefits of self-management interventions such as health and social care costs were scarce and a limitation to the current available literature, in particular with costs not directly related to healthcare. However, even though there is limited evidence of social care benefits, it is very likely that using self-management principles will also lead to savings in adult social care.

4. Patients' perceptions of self-management

Self-management is requested and well received by patients and healthcare charities which speak for patients.

4.1 Health charities and organisations

National Voices, is a coalition of English Health and Social Care Charities and supports the patients and citizens' voices. They are in agreement with using self-management principles for patients with long term conditions (19).

Many other condition specific charities also support and actively promote self-management, for example Parkinson's UK, Diabetes UK, the Alzheimer's Society, the British Lung Foundation and the British Heart Foundation.

There are also self-management specific charity organisations which promote self-management which are discussed in section 6.

4.2 Patient surveys

National Voices reviewed the patient surveys led by the Care Quality Commission and concluded there was feeling amongst patients that they were given inadequate support to look after themselves. In particular, one quarter of patients in the community with long term conditions did not feel there was enough help from local services to manage their condition. There was also uncertainty from patients after being discharged from hospital with regard to after-care, signs to watch out for and medications (19).

A survey commissioned for the Department of Health found that over 90% of patients with long term conditions would like to be more self-caring, 82% of patients who already feel they play an active role would like to be even more involved, and over 75% felt that they would feel more confident with managing their condition if they had support from healthcare professionals or peers (19).

4.3 Patient and public feedback to Hertfordshire's Self-management Strategy

During September-November 2016, focus groups were carried out with 48 patients with COPD and type 2 diabetes in Hertfordshire, on the subject of self-management. Over 90% agreed or strongly agreed with the

following statements, “Taking an active role in my own healthcare is the most important factor in determining my health and ability to function”, and “I am confident that I can take actions that will help prevent or minimise some symptoms or problems associated with my health condition”.

The principles of Hertfordshire’s Self-management strategy were also presented to the Watford and Three Rivers Patient event on the 17th November 2016. The strategy principles were well received by the patients present, but there were concerns raised by the patients about ensuring that the way the principles would be implemented would be accessible to all patients and that integration between different services would be achieved successfully.

5. National and local policy context

Self-management is a relevant topic and is important to achieving national and local policy goals. Nationally these include the Five Year Forward View, and locally the Hertfordshire and West Essex Sustainability and Transformation Plan (STP) and Hertfordshire’s Health and Wellbeing Board (HWB) Strategy.

5.1 National context

Five Year Forward View

The Five Year Forward View was published in 2014 as a “shared vision for the future of the NHS”, and includes many principles shared with self-management (24).

The main points from this document relating to self-management are:

- Empowering people’s access to information about their condition.
    - This includes clinical advice about their condition and their own past medical history
- Support for people to manage their own health.
    - This involves all stages of health, from staying healthy, taking a role in making informed choices about their treatment, managing their condition and complications.
- Direct patient control over the care they receive
- Engage communities and citizens with health and care services
    - Support for patients and carers could utilise community services, which could be voluntary and peer-to-peer services.
    - This requires strong partnerships between the NHS, charitable and voluntary organisations.
- Use technology to connect patients to doctors and nurses
    - This will support patients in managing their own health.

Hertfordshire’s self-management strategy will support these aspects of the Five Year Forward View.

Other national policies or bodies advocating self-management

There is reference to ensuring and encouraging patients are involved or have opportunities to be involved in their care in the NHS Constitution and the Health and Social Care Act, which concur with self-management principles.

The Care Quality Commission has also advised that patients are given different options with regards to the management of their conditions and are in control of their care.

Other CCGs such as NHS West Kent and Manchester have self-management strategies that can be found in the public domain (9; 25).

5.2 Local policy in Hertfordshire

Using a self-management strategy can help Hertfordshire achieve some of its visions and plans outlined in the HWB strategy and STP.

Health and Wellbeing Board (HWB) Strategy

The latest HWB strategy for 2016-2020 describes the high level priorities for improving health and wellbeing in Hertfordshire's population, using a life stage approach.

Self-management in particular links with 3 principles:

4. Focus on preventive approaches – helping people and communities to support each other and prevent problems from occurring for individual and families in the future
5. Always consider what we can do better together – focusing our efforts on adding value as partners to maximise the benefits for the public
6. Encourage opportunities to integrate our services to improve outcomes and value for taxpayers.

Within the different life stages, self-management (with its emphasis on long term conditions) is related to:

- Starting well
    - Put a greater focus on the mental health of women in the period immediately before and after birth
- Developing well
    - Strive to address the wider causes of poor mental health in children and young people, and support those who are experiencing mental health problems
- Living and working well
    - Strive to address the wider causes of poor mental health and support those who are experiencing mental health problems to recover or manage their condition
- Aging well
    - Strive to enable people aged 65+ to remain physically active and reduce levels of frailty
    - Seek to reduce hip fractures and injuries due to falls in people age 65+
    - Support people aged 65+ to regain their independence following a stay in hospital.
    - Seek to reduce preventable winter deaths in people aged 65+
    - Seek to improve the support, care and quality of life of people with dementia and their family carers.

Self-management services will be important to achieving these aims set out by the HWB.

Self-management is also closely linked to the "Strategic Shift to Prevention" work which is led by the HWB.

Sustainability and Transformation Plan (STP) 2016.

Self-management can be incorporated into all main 3 priorities in the STP set out by the Hertfordshire and West Essex footprint.

1. Deliver sustainable high quality acute care seeing only the patients that need to be in that setting
2. Fully integrated community services across primary community mental health and social care with prevention and self-care, based on defined communities, delivering care in or near home.
3. Whole system focus on preventing ill health and promoting well being

Self-management services will have an important role in helping achieve the priorities of the STP.

Other work in Hertfordshire

Self-management is related to the work being done by both Hertfordshire CCGs (Herts Valleys and East and North Hertfordshire) on LTCs and integrated self-management pilot in the Home First Integrated Care teams.

The Community First model is currently being developed by the Health and Community Services in Hertfordshire County Council. It aims to support people within their community rather than immediately referring someone to statutory adult social services. Options when a person initially requires support can be explored within the community setting. This can include help provided by friends, family and community based facilities first then stepping up to specialist services and technical equipment if and when it is required. Examples of community based services could include support groups.

6. Current self-management support nationally and in Hertfordshire

6.1 National self-management support

There are many national organisations which are advocating the use of self-management.

National organisations involved with or promoting self-management include:

- The King's Fund
- Self-Management UK
- The Health Foundation
- Nesta's People Powered Health Programme
- The Self Care forum
- The Expert Patients Programme
- Talking Health

Condition specific national charities involved with self-management are listed in section 4.1.

6.2 Hertfordshire self-management support

In Hertfordshire at the moment, there are services available which have a focus on self-management. Two examples include: Breathe Easy, a peer support group for COPD patients in Bishop's Stortford and in Stevenage there is a diabetes peer support group, called Type2Together.

New Leaf, a Hertfordshire Wellbeing College was launched in November 2016. It aimed to teach self-management skills to improve mental and physical wellbeing to people aged over 18 years old in Hertfordshire, using a structured tutor and peer tutor settings. Collaboration and co-production between people with personal experience of the conditions and professionally trained staff are the key to the success. So far, 23 students aged 24-84 have enrolled and feedback has been positive (January 2017). More courses are being developed and there is a plan to reduce the age of eligibility to 16 years.

Services offering self-management are not currently coordinated across providers and commissioners and there is no comprehensive list of which services are available in Hertfordshire for adults and children with LTCs.

There is work ongoing to identify self-management services are available, and an online self-management hub is under development which will sign post patients with long term conditions to specific self-management groups based on their condition.

7. Hertfordshire's principles for self-management

This strategy is aimed at all commissioners, providers, health and social care professionals, the voluntary sector and communities who are involved with services for adults and children with long-term conditions across Hertfordshire.

7.1 Aim

Our aim is to improve the health and wellbeing of Hertfordshire's population by embedding the principles of self-management across the health and social care system.

In particular, this current strategy will target adults and children with LTCs.

7.2 Principles and examples of delivery

These aims will be achieved by the ensuring the principles of self-management, listed below, are adopted into all existing and new commissioned services for long term conditions. Examples of existing services or techniques for each principle illustrate how Hertfordshire's commissioners and providers can demonstrate and support that principle.

7.2.1 Culture and leadership

Principle 1: Develop a culture of supporting self-management amongst the Hertfordshire population and all who work with patients with long term conditions, led by effective and strong clinical leadership.

It is essential that all stakeholders involved are signed-up to the self-management principles with a team to lead the change. They will need to be the leaders with the vision and inspiration to motivate all towards a culture of self-management. This group will ensure that the principles of self-management are embedded into all service plans.

Self-management culture must be ingrained into every day working practice for all who work with patients with LTCs. This also includes working with their families and carers. Staff at all levels should understand the benefits of a self-management style of working and be encouraged to make a coordinated effort towards that, supported by their peers and superiors. Training for self-management is discussed in principle 5.

All staff need to be supportive of self-management principles, and foster a working culture of self-management. Employees need to feel motivated to make changes and be welcome to discuss concerns and new ideas with their managers.

7.2.2 Approach to a self-management style of working

Principle 2: Provide a collaborative, integrated and personalised approach to self-management services support all and encourage shared decision making.

There are many ways that self-management can be embedded into the everyday work of professionals working with patients with long-term conditions, and there are many ways to support self-management.

The approach to patient consultations and management of conditions should be tailored to individual patient's needs using collaborative working practices with the patient to encourage shared decision making. This style of working is already happening in Hertfordshire and across the country, but more work needs to be done to ensure this becomes the working cultural norm rather than an exception.

This enables patients to feel empowered and involved in their treatment and care decisions, improving compliance and satisfaction with health and social services. Examples of consultations include motivational interviewing, agenda/goal setting, action planning and using tools to help patients prepare for consultations (20).

Social prescribing

Social prescribing involves "connecting people to non-medical sources of support or resources in the community which are likely to help with the health problems they are experiencing" (26). It is a method of "linking primary care with sources of support within the community" (27). This is an important resource in supporting self-management for many LTCs. Examples of social prescribing could be volunteering services, befriending schemes, physical activity programmes or initiatives that can help people with benefits, debt or legal advice (28).

Support for specific conditions

Although some patients with LTCs may attend services aimed at a range of conditions, there also needs to be specific support aimed at specific conditions. Specific support also needs to be provided for groups such as high risk or frequent attenders to A&E which may need one-on-one individualised self-management support. Many patients may also have multiple long-term conditions. It is important that their needs are specifically supported. This could be carried out using self-management principles in a multi-disciplinary setting. More details about structured courses and recovery colleges are in examples 1 and 2.

Example 1 – Structured courses for specific diseases

"Dose Adjusted for Normal Eating" (DAFNE)

www.dafne.uk.com

DAFNE aims to improve the lives of patients with type 1 diabetes by delivering a 5-day, small group structured course, led by a DAFNE-trained Educator (specialist nurses and dietitians). Attendees learn how to manage their blood sugar levels effectively using diet and insulin and prevent the complications of diabetes. There is a follow up session at 8 weeks after the course. Participants are encouraged to share their experiences, but can also discuss issues with their DAFNE Educator privately. The DAFNE programme also includes the DAFNE educator programme, doctor programme, peer review, audit and internal quality assurance.

So far, 5,815 DAFNE courses have been completed by 39,793 DAFNE graduates.

Example 2 – Recovery Colleges

Sussex Recovery College
www.sussexrecoverycollege.org.uk

This Recovery College provides courses focused on mental health conditions, with the aim of improving knowledge and self-management skills. Their mission is to "inspire hope and empower people to take control of their own recovery through learning". This is via one-off workshops and longer courses, and led by peer trainers, carer trainers and mental health professionals. People affected by mental health conditions, such as patients, carers, friends, family and those working in mental health services in the area are eligible to attend the college. Courses range from those targeting specific conditions, such as "Coping with bipolar" and "Managing depression" to generalised topics, "Happiness" and "Discharge to Recovery".

Evaluation of the programmes using standardised wellbeing, recovery and quality of life questionnaires and course feedback have been very positive. Students praised the delivery of the course which utilised peer trainers with the condition and others with a professional or clinical background.

Online programmes

Specific online programmes and forums to help people understand their condition, access info or learn techniques like relaxation. They can be one aspect of a larger programme which also involves structured face-to-face or group sessions, such as "My Health, My Way". Accessibility can be flexible as services can be accessed via apps, or connect to users through text messages or video games (14).

HealthFriends is a website which connects patients with health professionals online and the opportunity to chat to local people with similar conditions in forums (29).

Peer support groups

Peer support involves people with lived experience of a condition to give emotional and practical support and advice to others with the same condition or experiences. There are many benefits of peer support, and these can be felt by those receiving or providing the support. For the recipient, they can feel more self-confident and less alone in their experience, and build up a social network. The provider can also feel a sense of satisfaction that they are helping others, and both recipient and provider can learn from each other. One example of a peer support group is the Expert Patient Programme, which is described in example 3.

Example 3- Peer support groups

The Expert Patient Programme (EPP)

This is a peer led programme to educate patients with LTCs to manage and monitor their symptoms. There are programmes nationwide. It is led by a mixture of health care professionals and people with LTCs. In 2013, at least 5,000 EPP courses had been run and reached over 70,000 participants (39).

In Lambeth, EPP is delivered in a 6 week programme, with available topics such as "Dealing with pain and fatigue", "Communicating with family, friends, health professionals and social services" and "Preventing falls and improving balance" (40) .

Participants feel more self-confidence and feel less alone in coping with their condition. One attendee commented, "I walked in alone, but afterwards, I felt more self-worth and self-confidence. It was great to meet like-minded people, with similar issues (40)."

Patient or client consultations

This is a collaborative style of working between the patient or client and the professional. This involves patients or clients setting their own aims and working together with the health or social care professional and developing the problem solving skills to achieve their goal. Goal setting and action planning support the person to achieve the goals they want by breaking it down into more manageable actions.

The content of patient consultations should be holistic and tailored to specific circumstances of the patients, carers and their medical conditions. Consultations should take into account different levels of health literacy and patient and carer confidence and adjusted accordingly.

Tailored content for patient consultations should include education of the condition and treatments with practical advice (e.g. social, psychological support) for the patient, their carers and families. Several options should be given at consultations to ensure a patient's individuality can be accommodated and shared decision making should be emphasised. Using these methods of consultations may also empower the healthcare professional and patient to practice quaternary prevention to avoid overmedicalisation. This can be achieved by giving the relevant medical information and confidence to the patient to help them make their own decisions based on their circumstances and information about the risks and benefits of treatments. Advanced decision making should also be encouraged.

One-to-one coaching can be done face-to-face or remotely via Skype or over the phone, and utilise techniques such as motivational interviewing and goal setting (see example 4). This aims to improve self-efficacy and confidence.

Pharmacists, GPs and other healthcare professionals can also play a role in optimising medicines management with patients with multiple LTCs. Pharmacists, for example, could work with GPs and patients with multiple co-morbidities to review their often long list of medications.

Example 4 – use of self-management in a patient consultation

Motivational interviewing questions for weight loss (41)**:**

"Looking at your eating habits, I think the biggest benefits would come from switching from whole milk dairy products to fat-free dairy products. What do you think?"
"Have you ever attempted weight loss before? What was helpful? What kinds of problems would you expect in making those changes now? How do you think you could deal with them?"
"Which family members or friends could support you as you make this change? How could they support you? Is there anything else I can do to help?"

Goal setting example

Instead of the goal of "losing weight", the goal would be to "lose 4kg in 6 weeks" with specific guidance on exercise or diet.
Goals need to be followed up with positive encouragement of a patient's efforts and analyses of the challenges of achieving the goal.

Special and hard-to-reach groups

Self-management approaches should reach all patients who require it and patient consultations should be flexible to adjust for differences between patients.

The same high quality service should reach people from all different socio-economic backgrounds, genders, ages, religion or beliefs, sexual orientation and types of medical conditions. In particular, hard-to-reach and vulnerable groups should be identified. The diabetes group, DESMOND, has a specific programme for people with newly diagnosed or established Type 2 diabetes from South Asian communities.

Localised services

All services must be planned within the local context of services in Hertfordshire.

Within this strategy, services can set their own priorities and goals to bring a sense of ownership locally to those providing services.

7.2.3 Approach to implementing and commissioning services

Principle 3: Use a whole system approach to implementing and commissioning services.

Collaboration and integration

Collaborative but flexible working between health and social care professionals, voluntary services and communities, with change integrated at all levels of health and social care.

In an overstretched health service, voluntary services and communities can provide invaluable support and should be fully utilised. Current and future work done by health and social care professionals, voluntary services and communities needs to be integrated and collaborative with regard to service design and implementation. The principles of self-management should be involved at every level of health and social care.

There is evidence that moving patients between care providers or from discharge from a care provider to home can lead to unintended changes or errors to medication (30). A national audit published in 2016 showed that there were communication problems regarding medication changes during the transfer of patients between secondary and primary care (31). The Royal Pharmaceutical Society has recognised the importance multi-disciplinary approaches to working to tackle this problem and set out guidance and support for programmes to improve information transfer and collaboration between providers (30).

Voluntary services

The integration of voluntary care can be successfully integrated into current pathways and be invaluable in supporting self-management of the local population. This has been demonstrated in Rotherham, with the local Age Concern piloting a Hospital Aftercare Service (see example 5) and showing considerable economic and social benefits (32). However, the current system is not integrative and the different sectors may not fully understand each other's' roles and the full potential of benefits that voluntary care can provide (33).

Collaboration and integration will be aided by clear, accessible information which is described in principle 4. It is important that those involved in delivering self-management understand where they stand in the larger system.

Even though there should be clear aims and goals, there needs to be certain flexibility with regard to implementation in line with the individual and changing needs of patients.

Example 5 – Integration with voluntary services

Age Concern Rotherham's Hospital Aftercare service (32)

Age Concern Rotherham developed a 2 year pilot programme which supported older people on discharge from hospital who did not qualify for homecare under the Fair Access to Care Services criteria in Rotherham. The service consisted of:

1) 7 day intensive support package for people newly discharged from hospital or people in the community with an exacerbation of their LTC. This included hospital ward assessments, support at home with preparing meals, shopping, paying bills, cleaning and laundry, help with taking prescribed medications and identifying benefit entitlements.
2) Enabling services for people following usage of the intensive support package above or if a need for enabling services is required. Support included help at home preparing meals, shopping, cleaning and laundry, assistance to take part in activities to reduce social isolation, befriending and advice on leading a healthy lifestyle.
3) Telephone support services to those using the intensive or enabling services, to combat social isolation or helping with a particular problem.

The estimated economic saving was £1.1 million a year and over 90% of users improving their "confidence, mobility, motivation and independence" (32).

Community services

Support which can be found in the community can be an underutilised resource. Engaging communities can help to access groups who are hard to reach, such as people with a lower socio-economic status or particular cultural groups or who speak a different language. Working with communities can help raise awareness of self-management services and be more willing to use them. In addition, members of the public can become community health champions and work together with the existing health services to support self-management principles, such as the Altogether Better scheme in example 6.

Example 6: Integration of the community and public

Altogether Better

This award winning programme was started in 2008 and involves over 18,000 volunteers as community health champions (43).

This scheme works with General Practices and relies on patients, carers and members of the community "gift(ing) their time, energy, interest and enthusiasm to work as equal partners in making a real difference to the lives of others" (44). They do this by becoming volunteer "Practice Health Champions" who can help deliver social groups and activities such as a Ukulele group, a breastfeeding support group in Leeds or supporting the seasonal flu clinic (44).

General practices have reported a reduction in consultations in primary and secondary care, therefore reducing pressures on staff and improving staff morale. Patient participants of the scheme also reported improved mental health and wellbeing. It is hoped that this will improve the resilience of general practice, change the culture towards prevention and changing the way people use health services (44).

Use of Information Technology

Information technology (IT) improves continuity across self-management services commissioned across a range of providers or if patient care involves different healthcare and social care professionals. IT can also facilitate remote consultations using telephone or Skype consultations using an online shared electronic care plan. Self-management can also be supported using generalised or personalised emails and texts.

Examples of successful programmes using IT services include A Local Information System for Scotland (ALISS) project, which aims to help signpost people to useful community support, and the telehealth services in Newham (example 7).

Example 7 – IT services to support self-management

Telehealth in Newham (42)

This programme consists of different levels of telehealth based on need of the patient. One example is Philips Motiva. This provides educational videos on a condition which can be replayed and shared with family and friends. It is also interactive as patients can enter their details such as their weight, and if their weight increases, they can be sent a video on weight management. After a week, the system will send a follow-up questionnaire, and dependent on the results, a telehealth nurse will call and discuss weight loss and other issues with the patient.

Another component to the programme is Flo, which is used in the diabetic specialist nursing service. SMS text messages can be sent to patients with reminders, or patients can send their personal readings and be given advice. Readings can be sent at any time of the day and a response can be sent immediately. If a reading is outside of specific parameters, their specialist nurse will be contacted.

The team is made up of two community matrons, one nurse and four telehealth support workers. The project is commissioned as part of the community services contract. Rather than being commissioned by specific disease area, this programme recognises many patients have multiple co-morbidities and is therefore in the diabetes, heart failure, hypertension and chronic obstructive pulmonary disease care pathways.

Sustainable change

Changes toward a complete system-wide self-management practice can be incremental and do not need to be done all at once. To create sustained change, it is important that it is done over time with opportunities to evaluate and improve (20).

Sustainability of the services needs to be acknowledged and taken into account when commissioning.

7.2.4 Promotion and accessibility

Principle 4: Ensure information regarding self-management services is widely promoted and easily accessible.

At the moment, there is no single point of information on the self-management services for adults and children available in Hertfordshire. To ensure services are accessible to all and for effective planning and evaluation of services, it is important there is a central and up-to-date service which provides a current list of all the self-management services in Hertfordshire.

Access to self-management needs to be widely promoted, especially amongst vulnerable and hard to reach groups. This can be done by ensuring awareness among health and social care professionals, the local community groups and voluntary care services (see example 8).

Example 8 – Identifying groups and disseminating information

Mythe Medical Practice
www.jesmondhousepractice.nhs.uk

This general practice promotes information to people identified as carers. This included advice on local services and specifically what could be offered to them by the GP practice. A regular newsletter was also provided on local initiatives to support carers such as relief trips, local support groups, contacts and hints and tips for their peers.

7.2.5 Training the workforce

Principle 5: Establish consistent and effective support of the workforce

Training is aimed to ensure all who work with patients, carers and families of patients with long term conditions understand self-management principles and are confident in implementing these principles into their daily working practices. There should be a structured and uniform training programme with consistent messages for existing and new employees and providers.

There needs to be support for employees at all levels to help incorporate changes to their daily work. They should scrutinise the way they are working and be supported to change their practice accordingly. Although many may believe they are already working in this way, their interpretations of self-management should be checked to ensure there is a universal understanding of the principles of self-management. Others may be new to self-management and be resistant to new methods of working. These people will also need more support and training.

A team based approach towards training can be highly effective and encourages support between peers and shared responsibility (18). A more practical style of teaching such as role play and using shared experiences to illustrate principles could also be useful.

Training sessions could include teaching effective methods of motivational interviewing, agenda/goal setting and action planning.

Regular sessions to “check-in” and offer support with problems could also strengthen a culture of inclusiveness and positivity

7.2.6 Evaluation

Principle 6: Regular evaluation which is feasible and with active improvement of services.

Evaluation of interventions is crucial and is required to determine effectiveness against intended aims and objectives, if implementation was as planned and to explore reasons for successful or unsuccessful outcomes.

Resources for evaluation should be embedded into the implementation plan and should be realistic and feasible. The results of evaluations should be acted upon and as part of an ongoing process for improving services. Results from evaluations should be shared and can be used to encourage employees to maintain their success or motivate them to achieve more.

Examples of outcomes to evaluate effectiveness (20):

- Patients' self-efficacy, knowledge, feeling of empowerment, satisfaction and quality of life.
- Patient adoption of "healthy" behaviours or other change in behaviour
- Employee opinions
- Clinical outcomes e.g. attendance to A&E and general practices
- Costs and resource utilisation of services

There are a range of methods to evaluate service user views on interventions, such as Patient Reported Outcome Measures (PROMS) and Patient Activation Measure (PAM). Qualitative methods such as surveys, interviews and focus groups are also helpful at services and organisational level, job satisfaction and observing clinical encounters can be used.

Self-management UK and Southend-on-Sea Borough Council has developed a Patient Activation Measure (PAM) to assess a person's knowledge and confidence in living with long-term conditions. This can also be used to evaluate outcomes. They are currently using this in a pilot project in 2016 and the results are still awaited (34).

A library of evaluations of interventions for self-management may be useful for future planning of interventions and to learn from previously commissioned projects.

8. Strategy Implementation Table 2017-2020

See APPENDIX TWO

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Appendix 2: Hertfordshire Self-management Strategy Implementation Plan

Principle	Recommendations	Rationale	Delivering strategy Year 1 (2017-18)	Identified organisational lead	Year 2 (2018-19)	Year 3 (2019-20)
1. Develop a culture of supporting self-management amongst the Hertfordshire population and all who work with patients with long term conditions (LTCs), led by effective and strong clinical leadership.	It is essential that all stakeholders involved are signed-up to the self-management principles with a team to lead the change.	The system leaders need to provide the vision and inspiration to motivate staff, patients and the Hertfordshire population towards a culture of self-management. This self-management steering group will also need to ensure that the principles of self-management are embedded into all provider contracts, key performance indicators (KPI) and outcomes.	• Leadership is currently provided by the Hertfordshire Self-management Steering Group • Organisations to identify and train self-management champions within each management level	• Chair of Self-management steering group • All health and social care organisations within the STP footprint	• New contracts with providers to include requirements for self-management training into the induction programme and on-going development.	• Evaluation of changes in practice by staff after implementation of staff training.
	Self-management culture must be ingrained into every day working practice for all who work with patients with LTCs.	Staff at all levels should understand the benefits of a self-management style of working and be encouraged to make a coordinated effort towards that, supported by their peers and superiors. Training for self-management is discussed in principle 5. This change in culture and training will ensure universal knowledge and language of self-management principles amongst all staff.	• Develop and deliver a cohesive communication plan across the providers to raise awareness within organisations and with the general public with consistent messages. • Embed into staff culture and development by incorporating self-management into objectives at annual appraisals. For example, an objective could be to complete the online training on self-management.	• STP communications team • All health and social care organisations within the STP footprint		
	All staff need to be supportive of self-management principles, and foster a working culture of self-management.	Employees need to feel motivated to make changes and be welcome to discuss concerns and new ideas with their managers.				

2. Provide a collaborative, integrated and personalised approach to self-management services to support all and encourage shared decision making.	The approach to social care assessments, patient and client consultations and management of conditions should be tailored to an individual person's needs using collaborative working practices with the patient to encourage shared decision making.	This enables people to feel empowered and involved in their treatment and care decisions, improving compliance and satisfaction with health and social services. This would also involve working together with carers and families. Social prescribing can support self-management by linking patients and clients to non-medical sources of help and resources within the community. This also links to the whole system integrated approach in principle 3. There needs to be services and support aimed at specific conditions and also those with multiple long-term conditions. Examples of specific services for specific conditions include DAFNE (see page 24) and recovery colleges such as Sussex Recovery College (see page 24). A range of options should be available for patients with LTC to be able to choose which method is best for them, depending on their needs and availability (for example support can be accessible remotely online or out of working hours). Online programmes include My Health, My Way and HealthFriends (see page 24). Peer led support is valuable and has benefits for both the receiver and provider. The Expert Patient Programme is a national peer led programme to educate patients with LTCs to manage and monitor their symptoms (see page 25). Mythe Medical Practice signposts carers to peer support groups in addition to other support (see page 30).	• Encourage existing multi-disciplinary teams in HV and E&N Herts CCGs to work using the principles and techniques of self-management, such as motivational interviewing and goal setting for all patient consultations and assessments carried out by health and social care professionals. For example, goal setting of achievable and manageable targets such as losing 4kgs in 6 weeks. This will require upskilling of staff (see principles 1 and 5). • Adopt a single written care plan across Hertfordshire which involves shared discussion between a patient with LTCs and the health or social care professional and be accessible by all health and social services involved with the patient. • Scope out working with community pharmacists e.g. medicines use reviews to support patient • Promote and monitor	• HV and E&N Herts CCG • E&N Herts • Self-management	• Use findings identified from gap analysis, work with commissioners to fulfil unmet needs. • All health and social care teams working in Hertfordshire using self-management techniques and principles. • Continue to scope out, promote and monitor more local CQUINs. Commissioners and providers should make every effort to ensure that these targets are met. • Implementation of new risk stratification tools.	• Full evaluation of the extent staff use self-management and impact on outcomes

	The content of patient consultations should also be holistic and tailored to specific circumstances of the patients, carers and their medical conditions.	Tailored content for patient consultations should include education of the condition and treatments with practical advice (e.g. social, psychological support) for the patient, their carers and families. Several options should be given at consultations to ensure a patient's individuality can be accommodated and shared decision making should be emphasised. Consultations should take into account different levels of health literacy and patient and carer confidence and adjusted accordingly. Quaternary prevention principles can be practices which can reduce overmedicalisation. Pharmacists, GPs and other healthcare professionals can also play a role in optimising medicines management with patients with multiple LTCs. Content of consultations should utilise motivational interviewing, goal setting and problem solving in consultations (see page 26).	CQUINs in health improvement, for example tobacco screening of all adult patients is planned to be a CQUIN in 2017/18. Commissioners and providers should make every effort to ensure these targets are met. The Self-management Steering Group can support this. • Undertake self-management gap analysis and qualitative analysis of needs • Support to deliver outcomes to be provided by the Self-Management steering group.	steering group • All healthcare providers • Self-management steering group		
	Self-management approaches should reach all patients who require it and patient consultations should be flexible to adjust for differences between patients.	The same high quality service should reach people from all different socio-economic backgrounds, genders, ages, religion or beliefs, sexual orientation and types of medical conditions. In particular, hard-to-reach and vulnerable groups should be identified, such as high risk and frequent attenders who may benefit from more one-to-one support. Specific ethnic groups are also available. For example, the diabetes group DESMOND has a specific programme for people with newly diagnosed or established Type 2 diabetes from South Asian communities.	• Support risk stratification tools • Pilot of co-locating Increasing Access to Psychological Therapies (IAPT) services within LTCs services, giving patients with diabetes and respiratory conditions access to a high intensity worker.	• HCC and HV and E&N Herts CCGs • Integrated Health and Care Commissioning Team (IHCCT)		
	All services must be planned within the	Within this strategy, services can set their own priorities and goals to bring a sense	• Development of new mental and physical health wellbeing college,	• IHCCT		

	local context of services in Hertfordshire.	of ownership locally to those providing services.	New Leaf, based on the Recovery College model, using structured courses lead by tutors and peer tutors.		
3. Use a whole system approach to implementing and commissioning services	Collaborative but flexible working between health and social care professionals, voluntary services and communities, with change integrated at all levels of health and social care.	Current and future work done by health and social care professionals, voluntary services and communities need to be integrated and collaborative with regards to service design and implementation. The principles of self-management should be involved at every level of health and social care. The integration of voluntary care can be successfully integrated into current pathways and be invaluable in supporting self-management of the local population. This has been demonstrated in Rotherham, with the local Age Concern piloting a Hospital Aftercare Service (see page 27) Support which can be found in the community can be an underutilised resource. Working with communities can help raise awareness of self-management services, especially within hard to reach groups and be more willing to use them. In addition, members of the public can become community health champions and work together with the existing health services to support self-management principles, such as the Altogether Better scheme on page 28. This will be aided by clear, accessible information which is described in principle 4. It is important that those involved in delivering self-management understand where they stand in the larger system. Even though there should be clear aims	• Single group having oversight of self-management and the overall vision and direction of the system-wide change. This group must include representatives from the commissioners and providers, including the NHS, social care and voluntary and community services. • Formation of a commissioning workstream. • Support the delivery of the Community First model by the Health and Community Services in Hertfordshire County Council. It aims to support people within their existing community and reduce the demand on statutory adult social services. Options when a person needs support can be explored first by their friends, family and community based facilities then specialist services and technical	• Self-management steering group reporting to STP boards • HCC • Health and Community Services	• Scope out further gaps where benefits can be gained by working in a collaborative way between health and social care professionals and the voluntary sector.	

		and goals, there needs to be certain flexibility with regards to implementation in line with the individual and changing needs of patients. Information technology (IT) can improve continuity across self-management services commissioned across a range of providers or if patient care involves different healthcare and social care professionals. IT can also facilitate remote consultations using telephone or Skype consultations using an online shared electronic care plan. Examples of successful programmes include the ALISS project and the telehealth services in Newham (see page 28 and 29).	equipment as and when required. Examples of community based services could be support groups.			
	Changes toward a complete system-wide self-management practice can be incremental.	To create sustained change, it is important that it is done over time with opportunities to evaluate and improve. Sustainability of the services needs to be acknowledged and taken into account when commissioning.				
4. Ensure information regarding self-management services is widely promoted and easily accessible	A central hub which collates information on all available generalist and specialist self-management services is essential and would signpost healthcare professionals, the public, patients and their carers to the services (public and voluntary) in Hertfordshire and nationally.	To ensure services are accessible to all and for effective planning and evaluation of services, it is important there is a central and up-to-date service which provides a current list of all the self-management services in Hertfordshire. Access to self-management need to be widely promoted especially amongst vulnerable and hard to reach groups. This can be done by ensure awareness among health and social care professionals, the local community groups and voluntary care services. Carers were targeted in Mythe Medical Practice (see page 30).	• An online, publically available website which will collate information for many specific long term conditions including COPD, depression and anxiety, dementia and end of life care. Advice on managing these conditions, links to further information and details of national and local services for which support managing these conditions will be attainable on the website.	• Self-management steering group	• Scope out further development of the website. For example, this could include an online platform to support interactions between health and social care professionals and patients.	• Scope out the use of technology to support the delivery of self-management.
5. Establish	Training of the	Training is aimed to ensure all who work	• There is currently a	• HCT	• Evaluation and	

consistent and effective support of the workforce	workforce is important and requires team based approach.	with patients, carers and families of people with long term conditions understand self-management principles and are confident in implementing these principles into their daily working practices. This should be done using a structured and uniform training programme with consistent messages. There needs to be support for employees at all levels to help incorporate changes to their daily work. They should scrutinise the way they are working and be supported to change their practice accordingly. A team based approach towards training can be highly effective and encourages support between peers and shared responsibility. A more practical style of teaching such as role play and using shared experiences to illustrate principles could also be useful. Staff members should also be encouraged to practice self-management skills on themselves and take charge of their own health and wellbeing.	training module on Making Every Contact Count. This will be promoted and staff should be encouraged to complete it. • Train the local workforce by developing a self-management training package, which could include practical and e-learning type elements and embed this requirement into contracts with providers. This training can also help reduce the stigma of certain LTCs such as HIV. • Self-management workforce development task and finish group currently developing staff training and support systems, for example, teaching staff how to approach conversations regarding self-management with patients. • Promote and support CQUINs relating to improving the support available to NHS staff to improve their health and wellbeing (mental health, physiotherapy and physical activity	• HCT • HCT • HCT and all healthcare providers	further scoping of gaps in training received by staff • Evaluation of all existing and new programmes. • Over years 2 and 3 continue scoping out further gaps to align with current priorities.

			initiatives), ensure healthy food options and improve flu vaccine uptake. These indicators should be met by NHS organisations in Hertfordshire.			
6. Regular evaluation which is feasible and with active improvement of services	Resources for evaluation must be built into the self-management services implemented.	Evaluation of interventions is crucial and is required to determine effectiveness against intended aims and objectives, if implementation was as planned and to explore reasons for successful or unsuccessful outcomes. Resources for evaluation should be embedded into the implementation plan and should be realistic and feasible. The results of evaluations should be as part of an ongoing process for improving services. Results should be shared and used to encourage employees to maintain their success or motivate them to achieve more. Examples of outcomes to evaluate effectiveness are on page 31. Patient Reported Outcome Measures (PROMS) and Patient Activation Measure (PAM) can be used to evaluate service user views. Qualitative methods such as surveys and interviews are also helpful. At service level, job satisfaction and observing clinical encounters can be used. Self-management UK and Southend-on-Sea Borough Council has developed PAMs to assess a person's knowledge and confidence in living with long-term conditions (see page 28). A library of evaluations of interventions for self-management may be useful for future planning of interventions and to learn from previously commissioned projects.	• Develop standardised outcome measures, such as key performance indicators (KPI) to be incorporated into service specifications, and evaluation proposals will be a part of project plans to be used by commissioners. • The online hub discussed in principle 5 will be evaluated with interviews and focus groups with service users. • Conduct questionnaires on patient's knowledge and confidence in self-managing their condition. • Work with providers to identify interventions to be evaluated using PROMS. • Projects and service evaluations by commissioners and providers within Hertfordshire should be shared so everyone can	• All commissioning organisations • Self-management steering group • Self-management steering group • HCT • Self-management steering group		

			learn from achievements and problems encountered			

Appendix 3: EqIA

Guidance is available on Compass. Completion of an EqIA should be proportional and relevant to the anticipated impact of the project on equalities. The form can be tailored to your project and should be completed before decisions are made. Key EqIAs should be reviewed by the Business Manager or Service Head, signed off by your department's Equality Action Group (EAG) and sent to the Equality and Diversity team to publish on HertsDirect. For support and advice please contact equalities@hertfordshire.gov.uk.

STEP 1: Responsibility and involvement

Title of proposal/ project/strategy/ procurement/policy	Progress and developments in prevention: Self-management strategy and update	**Head of Service or Business Manager**	Jim McManus, DPH
Names of those involved in completing the EqIA:	Miranda Sutters, Consultant in Public Health	**Lead officer contact details:**	Jim McManus, Director of Public Health Tel: 01438 845389.
Date completed:	20/12/2016	**Review date:**	NA

STEP 2: Objectives of proposal and scope of assessment – what do you want to achieve?

Proposal objectives: – what you want to achieve – intended outcomes – purpose and need	Background: Self-management is where a person with long term conditions (LTCs) can take ownership for their own health and wellbeing. This can include physical or mental health, preventing accidents or health conditions, managing for minor health problems or LTCs and ensuring a good level of health after recovering from an illness or hospital admission. Self-management is not a specific action, treatment or service, but involves health and social care professionals, patients, carers and families working in collaboration towards a shared tailored management plan based on the patient's specific set of circumstances. These circumstances could depend on their medical conditions, health literacy, social and local support and confidence. Improving both medical and social care are linked to improved patient outcomes. Using self-management principles in a social care setting can help improve a patient's compliance and ability to follow medical management plans. For example, if a diabetic patient's social care needs of accommodation are met, they may be more able and motivated to focus on optimising the management of their diabetes. Support from the health and social care services is required to ensure the correct training and environment is available to accommodate this. Self-management principles can also be supported by an individual's social network. Self-management as a work stream is moving forward strategically to help support the delivery of prevention savings for the local health and social care system. It was agreed that the purpose and structure of the group would be reviewed to ensure that the work was aligned with other Long Term Condition (LTC) work streams, such as those led by both Hertfordshire Clinical Commissioning Groups (Herts Valleys and East & North Hertfordshire) and support the delivery of the local Sustainable Transformation Plan (STP).

	Since April 2016, in addition to the groups on-going projects they have been delivering the following: 1. Self-management strategy-an overarching three-year strategy has been developed which all member organisations are signed up to and which is supported by an implementation plan aligned to the STP priorities. 2. Workforce development-working with local providers to: ➢ Agree a competency framework for self – management ➢ Develop a template approach to assessing training need which can be used by all partner organisations ➢ Develop a multi-tiered training programme including materials (for both health and social care staff). ➢ Agreeing arrangements with partner organisations for embedding learning into staff development plans and capturing the impact on patients. 3. Online self-management information hub (siting on Herts Health web pages). This has involved consulting with various LTC patient groups to understand what they need to help support them managing their condition better. The content has been developed and IT support to 'build' the pages will be available from mid-January 2017. The website will be an important tool for Herts Help to navigate patients/clients to information and local support groups.
Stakeholders: Who will be affected: the public, partners, staff, service users, local Member etc	• Citizens of Hertfordshire (including those with existing LTCs) • Health and Community Services • Patients who have a LTC and are on a self-management plan • Provider and voluntary organisations • Members –

STEP 3: Available data and monitoring information

Relevant equality information For example: Community profiles / service user demographics, data and monitoring information (local and national), similar or previous EqIAs, complaints, audits or inspections, local knowledge and consultations.	**What the data tell us about equalities**
People's ethnicity, language and religion	

• The number of people from ethnic minority groups aged 50 and over is projected to increase from 1.7 million in 2007 to 3.8 million by 2026 (Lievesley, N. 2010). • Almost 20% of people in Hertfordshire belong to an ethnic group other than White British. 12% of Hertfordshire residents were born outside the UK or Ireland, and 6% do not have English as a first language (Hertfordshire's Equality and Diversity JSNA. 2014). • In Hertfordshire 3% of the over 65 population identify as Asian/Asian British which is similar to England but higher than the East of England (Hertfordshire's Equality and Diversity JSNA. 2014). • 23% of school age children in Hertfordshire identify themselves as being from non-White British ethnic groups (Hertfordshire's Equality and Diversity JSNA. 2014). • Nearly 10,000 people in Hertfordshire (1%) say that they are not proficient in English (Hertfordshire's Equality and Diversity JSNA. 2014).	• ONS data for Hertfordshire has revealed that the proportion of individuals reporting that they are in 'Not Good Health' is significantly higher amongst service users who report that they are 'not proficient in English' compared with those who claim to be 'proficient in English' – the differential is most pronounced in North Herts where the former exceeds the latter by 400% (Hertfordshire's Equality and Diversity JSNA. 2014). • Evidence from the Health Survey for England (2014) suggests that those of Indian, Pakistani and Bangladeshi origin are significantly more likely to report a diagnosis of diabetes
Sex	
• Hertfordshire is made up of 547,110 Males (49%) and 568,952 Females (51%) (Hertfordshire's Equality and Diversity JSNA. 2014).	• Females over 65 years of age are more likely to say they are limited in daily activities by a long term health problem or disability, particularly those from an ethnic group other than White British (Hertfordshire's Equality and Diversity JSNA. 2014). • Males from Black and Minority Ethnic groups are most unlikely to say that they are affected by a long term health problem or disability (Hertfordshire's Equality and Diversity JSNA. 2014).
Mental, intellectual, and physical health	

• 47% of the population over 65 years of age (78,000) say they are limited in daily activities by a health problem or a disability (Census, 2011) • Estimates suggest that 26,500 people in Hertfordshire (2.4% of the population) may have Learning Disabilities (Hertfordshire Learning Disabilities JSNA). • POPPI (Projecting Older People Population Information system) estimate that around 9% of those in Hertfordshire over 65 have depression, with women more likely than men to have depression. It is estimated that 3% of the over 65s have severe depression, again with women more likely than men to have severe depression (Hertfordshire's Equality and Diversity JSNA. 2014).	• In a survey of 2,000 people aged 55 and over, 14% said that they participated in sport and active recreation, at moderate intensity, for 30 minutes on 3 or more days a week. This compared to 26% of people aged 35-54 and 25% aged 16-43 (JNSA, Aging Well). • Social isolation is thought to be a contributing factor to depression and ill-health as well as being detrimental to pre-existing health conditions. Although not necessarily meaning they are socially isolated, many people aged over 65 live alone in Hertfordshire (Hertfordshire's Equality and Diversity JSNA. 2014). • Approximately 5566 people registered with a GP practice in East Hertfordshire had a recorded dementia diagnosis in 2011-12 which suggests that around 42% of people with dementia have a diagnosis. This is similar to the UK average of 44 % (JNSA, Dementia Profile). –
People living with long term conditions	
• The latest data from the 2010/11 Quality and Outcomes Framework (QOF) and the 2009 General Lifestyle Survey suggest that around 15m people in England have a long term condition. If the Hertfordshire proportion is applied to this figure then there are around 318,000 people living with long term conditions. (Hertfordshire's Long Term Conditions Needs Assessment. JSNA. 2016) ▪ • Around 70-80 per cent of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).	• The number of people living in Hertfordshire living with a LTC is likely to an underestimate as information is based on our population registered with primary care. Marginalised groups such as the homeless, undocumented migrants, travellers etc are more likely to engage with the health service through secondary care.

STEP 4: Impact Assessment – Service Users, communities and partners (where relevant)

– **Guidance on groups of service users to consider within each protected group can be found here**

Protected characteristic	Potential for differential impact (positive or negative)	– What reasonable mitigations can you propose?
Age	• The work-streams of the self-management steering group aims to provide a strategic direction to embed the principles of	• Through the delivery boards of our local STP, a key priority is 'Strategic Shift to Prevention' which aims to reduce cost to the system by implementing high

Protected characteristic	Potential for differential impact (positive or negative)	– What reasonable mitigations can you propose?
	managing your own condition(s) within our local health and social care system. This work is aligned to the delivery of the sustainable transformation plan (STP) priorities and its respective delivery boards. It will provide a framework to enable and support commissioners and providers. • Through adopting a joined up approach across our STP footprint to self-management we will maximise efforts to support our local population to understand and manage their own condition and reduce the burden on health and social care.	impact actions system wide to prevent worsening of health and management of cost. – • Workforce and organizational development to further develop an approach which supports interdependency e.g. Hospital Trusts Users Self-Management CQUIN • Develop a Communications Plan for self-management e.g. roll out of the information hub
Disability Including Learning Disability	• The work streams of the self-management steering group aims to provide better services and information to individuals with both learning and physical disabilities to ensure that they are supported to manage their LTC.	• Undertake ongoing, meaningful engagement with all groups to improve awareness and outcomes. • Greater use of the Public Health Board to link good practice at a district and county level • Explore how the learning from the ABCD work among people with learning disabilities can be shared and expanded across other sectors
Race	• The work streams of the self-management steering group aim to support patients with LTCs to manage their own health for individuals from all backgrounds.	• Undertake ongoing, meaningful engagement with individuals who share this characteristic to improve awareness and outcomes.
Gender reassignment	• No specific impact other than those found elsewhere in this analysis.	• Undertake ongoing, meaningful engagement with individuals who share this characteristic to improve awareness and outcomes.
Pregnancy and maternity	• No specific impact	• Undertake ongoing, meaningful engagement with individuals who share this characteristic to improve awareness and outcomes.
Religion or belief	• No specific impact other than those found elsewhere in this	• Undertake ongoing, meaningful engagement with individuals

Protected characteristic	Potential for differential impact (positive or negative)	– What reasonable mitigations can you propose?
	analysis.	who share this characteristic to improve awareness and outcomes.
Sex	• No specific impact other than those found elsewhere in this analysis.	• Undertake ongoing, meaningful engagement with individuals who share this characteristic to improve awareness and outcomes. – • Ensure contract monitoring specifically monitors areas of known inequality through the User Self-Management CQUIN e.g. uptake among older men
Sexual orientation	No specific impact other than those found elsewhere in this analysis.	• Continue to develop the Joint Strategic Needs Assessment to inform self-management priorities e.g. older lesbian, gay and bisexual and transgender people.
Marriage & civil partnership	No specific impact other than those found elsewhere in this analysis.	• Undertake ongoing, meaningful engagement with individuals who share this characteristic to improve awareness and outcomes.
Carers (by association with any of the above)	The work streams of the self-management steering group aims to raise awareness of importance of supporting carers to self-care/self-manage and enable carers to support their dependent(s) to manage their condition. Carers have been consulted as part of the development of the self-management information hub to ensure it reflects information they will find useful to support them in the caring role.	• Continue to develop the Joint Strategic Needs Assessment and explore how this might incorporate assets and locality level intelligence to inform commissioning priorities • Implementation of Carer Friendly Communities (as part of Carer strategies).
Opportunity to advance equality of opportunity and/or foster good relations (Please refer to the guidance for more information on the public sector duties)		

Impact Assessment – Staff (where relevant)

Protected characteristic	Potential for differential impact (positive or negative)	– What reasonable mitigation can you propose?
Age	No staff-specific impacts.	No staff-specific impacts.
Disability Including Learning Disability	No staff-specific impacts.	No staff-specific impacts.
Race	No staff-specific impacts.	No staff-specific impacts.
Gender reassignment	No staff-specific impacts.	No staff-specific impacts.

Protected characteristic	Potential for differential impact (positive or negative)	– What reasonable mitigation can you propose?
Pregnancy and maternity	No staff-specific impacts.	No staff-specific impacts.
Religion or belief	No staff-specific impacts.	No staff-specific impacts.
Sex	No staff-specific impacts.	No staff-specific impacts.
Sexual orientation	No staff-specific impacts.	No staff-specific impacts.
Marriage & civil partnership	No staff-specific impacts.	No staff-specific impacts.
Carers (by association with any of the above)	No staff-specific impacts.	No staff-specific impacts.
Opportunity to advance equality of opportunity and/or foster good relations (Please refer to the guidance for more information on the public sector duties)		

STEP 5: Gaps identified

Gaps identified Do you need to collect more data/information or carry out consultation? (A 'How to engage' consultation guide is on Compass). How will you make sure your consultation is accessible to those affected?	• Work with the Sustainable Transformation Plan (STP) communications team to ensure that there is consistent self-management messages/information provided to our local population. • Work with commissioners both individually and as part of a network to help identify gaps within their organisation/health and social care system and barriers to implement the self-management strategy.

STEP 6: Other impacts

Consider if your proposal has the potential (positive and negative) to impact on areas such as health and wellbeing, crime and disorder and community relations. There is more information in the guidance.

STEP 7: Conclusion of your analysis

Select one conclusion of your analysis	Give details
☐ **No equality impacts identified** – No change required to proposal.	
☐ **Minimal equality impacts identified** – Adverse impacts have been identified, but have been objectively justified (provided you do not unlawfully discriminate). – Ensure decision makers consider the cumulative effect of how a number of decisions impact on equality.	

Select one conclusion of your analysis	Give details
☒ **Potential equality impacts identified** – Take 'mitigating action' to remove barriers or better advance equality. – Complete the action plan in the next section.	The Self-Management steering group will review its priorities on an annual basis, the self-management strategy and implementation plan will be reviews on a quarterly basis and will report to the Public Health Board and STP delivery boards.
☐ **Major equality impacts identified** – Stop and remove the policy – The adverse effects are not justified, cannot be mitigated or show unlawful discrimination. – Ensure decision makers understand the equality impact.	

STEP 8: Action plan

Issue or opportunity identified relating to: – Mitigation measures – Further research – Consultation proposal – Monitor and review	**Action proposed**	**Officer Responsible and target date**
There is a need to regularly review the priorities of the self-management group to ensure the work that reflects local need. The strategy and it's corresponding implementation plan will also be reviewed on a quarterly basis ensure that it continues to achieve its aims and remains relevant to our population living with LTCs in Hertfordshire.	The Self-Management steering group will review its priorities on an annual basis, the self-management strategy and implementation plan will be reviews on a quarterly basis and will report to the Public Health Board and STP delivery boards.	Public Health Consultant leading on self-management Public Health Consultant leading on prevention Quarterly reviews during the operational period of the strategy
There is currently limited information about the barriers different groups of the population experience to self-manage. There is a need to understand these in order to support the commissioning/delivery of services to ensure that the services mitigate some of the potential inequalities.	Work with Public Health Information Team to provide information summaries which are people and place specific with the aim that these underpin the commissioning/delivery of local services to support self-management.	Public Health Consultant leading on Information and Knowledge Public Health Consultant leading on prevention Quarter 3, 2017, to be reviewed on an on-going basis during the operational period of the strategy.

Issue or opportunity identified relating to: – Mitigation measures – Further research – Consultation proposal – Monitor and review	**Action proposed**	**Officer Responsible and target date**
Lack of readily available information which could support the progress made to implement the self-management strategy across the county.	Work with commissioners/providers through the STP delivery boards to develop outcome measures to quantify whether the strategy objectives have been met.	Public Health Consultant leading on self-management Public Health Consultant leading on prevention Timeframe will be dependent of the commissioning cycle of a particular service.

This EqIA has been reviewed and signed off by:

Head of Service or Business Manager: Jim McManus Date: 17/01/2017

Equality Action Group Chair: Date:

HCC's Diversity Board requires the Equality team to compile a central list of EqIAs so a random sample can be quality assured. Each Equality Action Group is encouraged to keep a forward plan of key service decisions that may require an EqIA, but please can you ensure the Equality team is made aware of any EqIAs completed so we can add them to our list. (email: equalities@hertfordshire.gov.uk).
Thank you.