SBAR Progressing supported self-management in Grampian

Situation

Supporting self-management is a fundamental component of the move to develop person-centred health and social care services.[1] It is both simple and complex.

- Simple in that it straightforwardly follows from seeing the whole person in the context of their current circumstances, taking the time to understand the life they are aspiring to lead, the obstacles to that that their current health condition poses, and tailoring their care and treatment from that starting point.

- Complex in that this requires a shared understanding of care delivery between professional and patient, coordinated resources and actions across multiple organisations, services and teams, and involves organisational system and culture change.

Developed from published guidance and multi-organisation stakeholder discussions held in Grampian in late 2015 this report highlights seven key actions required across health and social care systems to drive progress in Grampian.

Background

Definitions

While the terms self-care and self-management are often used interchangeably, it can be helpful to differentiate between them.

- Self-care is sometimes used to refer to broad, everyday actions to maintain health and wellbeing, as well as self-directed treatment for minor ailments.

- Self-management is more often used to refer to the actions taken by those living with long-term health conditions.

Long-term health conditions in Grampian

Long-term health conditions include diabetes, asthma, depression, coronary heart disease, and chronic obstructive pulmonary disease. The shared characteristic of this diverse range of health conditions is that their symptoms are often treatable, secondary complications are often preventable, but the underlying pathology is not curable, with potential impacts on daily functioning and quality of life.

Many (though not all) long-term conditions are associated with ageing. The significant increases in longevity of the population has led to predictions of increasing prevalence of long-term conditions in Grampian. Many conditions are inter-related, such that developing one leads to an increased risk of developing others. By age 65 one in two people have multiple long-term conditions.

At any one time in Grampian there are around 11,000 people known to be living with cancer or stroke, 22,000 with heart disease and 26,000 with diabetes (see box below).

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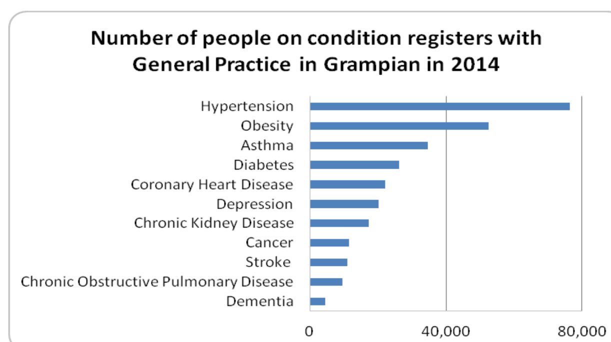
[1] http://personcentredcare.health.org.uk/

Grampian Primary Care Condition Registers ("QOF" registers) as of June 2014	Number of patients on register
Hypertension	76,000
Obesity	53,000
Asthma	35,000
Diabetes	26,000
Coronary Heart Disease	22,000
Depression	20,000
Chronic Kidney Disease	17,000
Stroke	11,000
Cancer	11,000
Chronic Obstructive Pulmonary Disease	9,000
Dementia	4,000
TOTAL*	**286,000**
*NB individuals can appear on more than one register	



Policy context

The national self-management strategy was published in 2008, and remains in place.[2] It was co-authored by the Long-Term Conditions Alliance Scotland (LTCAS, now "the Alliance" www.alliance-scotland.org.uk) and Scottish Government. This strategy highlights the importance of collaboration and participation, and of self-management being the result of services helping a person 'to live well'.

The report of the Christie Commission and subsequent associated legislation (e.g. Public Bodies (Joint Working) (Scotland) Act 2014;) is accelerating the national drive to create more person-centred public services that are collaborative and participative in nature. There is recognition that no single organisation can support people's health alone. People require a broad mix of opportunities for involvement and participation, and a rich selection of resources on which to draw, in the communities in which they live, to live their lives well.

Assessment

NHS Grampian (NHSG) has recognised the strategic importance of supporting self-management for a number of years. Social marketing campaigns have sought to help the public navigate the healthcare system,[3] modernisation programmes have supported the use of anticipatory care plans,[4] a digital platform has been created to support people's journey between primary and secondary care services,[5] programmes have been implemented to support health education in hospital settings,[6] and resources have been used to strengthen community-based pulmonary and cardiac rehabilitation.

The potential step-change comes from seeing these discrete services as part of a much greater whole, with a significant potential for synergy arising from collaborative endeavours across the entire tapestry of public, private and third sector resources woven into communities. Such collaboration seems more possible that ever amidst the current integration of health and social care, the strengthening of community planning and public participation in public services as a result of the Community Empowerment (Scotland) Act 2015, and NHSG modernisation of clinical services.

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[2] www.gov.scot/Publications/2008/10/GaunYersel
[3] www.know-who-to-turn-to.com
[4] www.nhsgrampian.org/grampianfoi/files/item05.1USC.doc
[5] www.nodelays.co.uk
[6] www.hphsgrampian.scot.nhs.uk

There is wide stakeholder support in Grampian to make this step-change a reality. Multi-stakeholder workshops in 2015 (appendix 1) confirmed local agreement with a range of principles for action consistent with the wide range of published resources available online (appendix 2).

Recommendations

Ensure that the human relationship is at the core of health and social care

Equal attention must be paid to people's psychological and social functioning as it is to remediation and/or mitigation of physical pathology. While communication skills are now a core component of all health and social care professional training, and online courses and resources abound,[7] professionals often have to work 'despite the system' to achieve this.

1. Collaborative communication, agenda setting and decision-making skills should be part of all health and social care professionals' annual appraisals and personal development plans

2. Organisational development and service improvement programmes should include a focus on the provision of collaborative, person-centred services

Local communities ***are part of*** *the health and social care system*

Health and social care services and professionals do not exist in isolation. Person-centred care requires a wider appreciation of the range of organisations and groups offering potential resources and support to people in their everyday lives. Matching physical, psychological and social functioning needs and local assets is a necessary aspect of care provision. This is a significant knowledge management challenge that organisations need to find solutions for.

3. The participation of those who use services in helping design, develop, improve and deliver services is a fundamental part of the Community Empowerment (Act) Scotland 2015. The opportunities for H&SCP and NHSG to co-create services with third sector and civil society groups should be grasped.

4. Alongside formal systems of social prescribing, new roles such as health coaches and community link workers are required, to help bridge the gap between healthcare services and their users' local communities

Creating and strengthening broader systems that support people to self-manage

Very little of learning to live with a health condition actually happens on healthcare premises. Yet finding answers to what it means to be living with a health condition, finding ways to cope with associated uncertainties and anxiety, increasing self-confidence and self-belief, and finding constructive ways to overcome health-related obstacles to everyday functioning are vital to developing an increased sense of being able to self-manage. H&SCP and NHSG Boards have a vested interest in seeing communities develop and strengthen a wide range of resources for people to draw on to support their own health.

5. H&SCP and NHSG must play an active role in Community Planning Partnership, helping to build healthier and stronger communities

6. H&SCP and NHSG should incorporate co-created peer support programmes into clinical services pathways:

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[7] e.g. www.healthliteracyplace.org.uk

a) Arthritis Care and the MS Society have experience of developing peer-led education programmes, which can potentially be adapted for a range of conditions, and the Wellness Recovery Action Planning (WRAP)[8] programme has been used across a range of settings in Scotland

b) befriending, buddying schemes and individual peer support systems, offering those who use services the opportunity to get involved and “give something back”

Resources and tools

7. A wide range of resources should be provided to give additional support to help people to self-manage:

- traditional and digital information and education for people and their carers
- self-monitoring resources
- virtual consultations via digital communication technologies
- telehealth devices and telephone services

Conclusion

This report is intended to assist Grampian’s NHS Board, Health & Social Care Partnership Boards and Community Planning Partnership Boards in their collaborative efforts to support the health and wellbeing of the population of Grampian.

Christopher Littlejohn
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[8] www.scottishrecovery.net/WRAP/wellness-recovery-actions-planning.html

Appendix 1 Stakeholder workshops 2015

A broad range of stakeholders have an interest in the self-management agenda. Two workshops were used to explore collaborative interests in October and November 2015. Stakeholders included representatives of:

- Aberdeen City Council
- Aberdeen Council of Voluntary Organisations
- Aberdeen Foyer
- Aberdeenshire Council
- Alliance Scotland
- Chest Heart and Stroke Scotland
- Community Renewal
- NHS Grampian
- Aberdeen City Health and Social Care Partnership
- Aberdeenshire Health and Social Care Partnership
- Robert Gordon University
- University of Aberdeen

Small groups discussions produced written materials, which were transcribed and analysed.

The analysis highlighted:

- health and social care as a human relationship
- seeing the community as part of the health and social care system
- the importance of mutual support

These points are incorporated into the SBAR recommendations.

Appendix 2 Additional resources

Health Foundation (2015) *A practical guide to self-management support: Key components for successful implementation* www.health.org.uk/publication/practical-guide-self-management-support

Health Foundation (2014) *Person-centred care: from ideas to action: Bringing together the evidence on shared decision-making and self management support* www.health.org.uk/publication/person-centred-care-ideas-action

Health Foundation (2012) *Co-creating Health: Evaluation of first phase* www.health.org.uk/publication/co-creating-health-evaluation-first-phase

Health Foundation (2011) *Helping people help themselves: A review of the evidence considering whether it is worthwhile to support self-management* www.health.org.uk/publication/evidence-helping-people-help-themselves

King's Fund (2015) Transforming our health care system: Ten priorities for commissioners www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners

King's Fund (2014) *Supporting people to manage their health: An introduction to patient activation* www.kingsfund.org.uk/publications/supporting-people-manage-their-health

King's Fund (2013) *Delivering better services for people with long-term conditions: Building the house of care* www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions

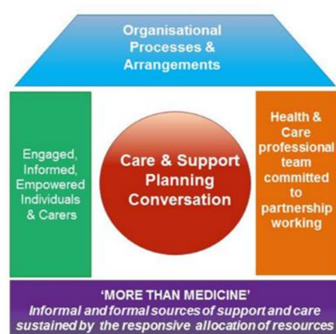
King's Fund (2011) *Making shared decision-making a reality: No decision about me, without me* www.kingsfund.org.uk/publications/making-shared-decision-making-reality

Many conditions, One life: Living Well with Multiple Conditions: An Action Plan to improve care and support for people living with multiple conditions in Scotland

National Voices *Supporting self-management: summarising evidence from systematic reviews* www.nationalvoices.org.uk/supporting-self-management

NESTA (2013) *More than Medicine: New Services for People Powered Health* www.nesta.org.uk/sites/default/files/more_than_medicine.pdf

Skills for Care Common core principles to support self care www.skillsforcare.org.uk/Skills/Self-care/Self-care.aspx



https://houseofcare.wordpress.com/