Terms of Reference

Grampian Clinical Strategy Supported Self-Management Transformation Programme Board

Purpose

The Transformation Programme Board (TPB) will lead the implementation of Supported Self-Management under the auspices of the Grampian Clinical Strategy.

Scope

1. Provide strategic oversight for supported self-management across Grampian
2. Coproduce the implementation of *House of Care* across Grampian
3. Engage and cooperate with those leading relevant service developments across health and social care systems and wider partnerships, to realise synergies between other service developments and *House of Care*
4. Oversee communications from the TPB
5. Establish and monitor routine data surveillance systems and evaluation outputs

Initial stakeholder group – see PID.

Chair

The Board will be chaired by Chris Littlejohn, interim Deputy Director for Public Health

Meetings of the Transformation Programme Board (TPB)

Frequency – the TPB will meet quarterly

Venues – the TPB will meet at NHS Grampian headquarters, Summerfield House

Terms of Reference

Governance and Reporting – the TPB will be accountable to the NHS Grampian Senior Leadership Team chaired by NHS Grampian Chief Executive, and reports will be provided to:

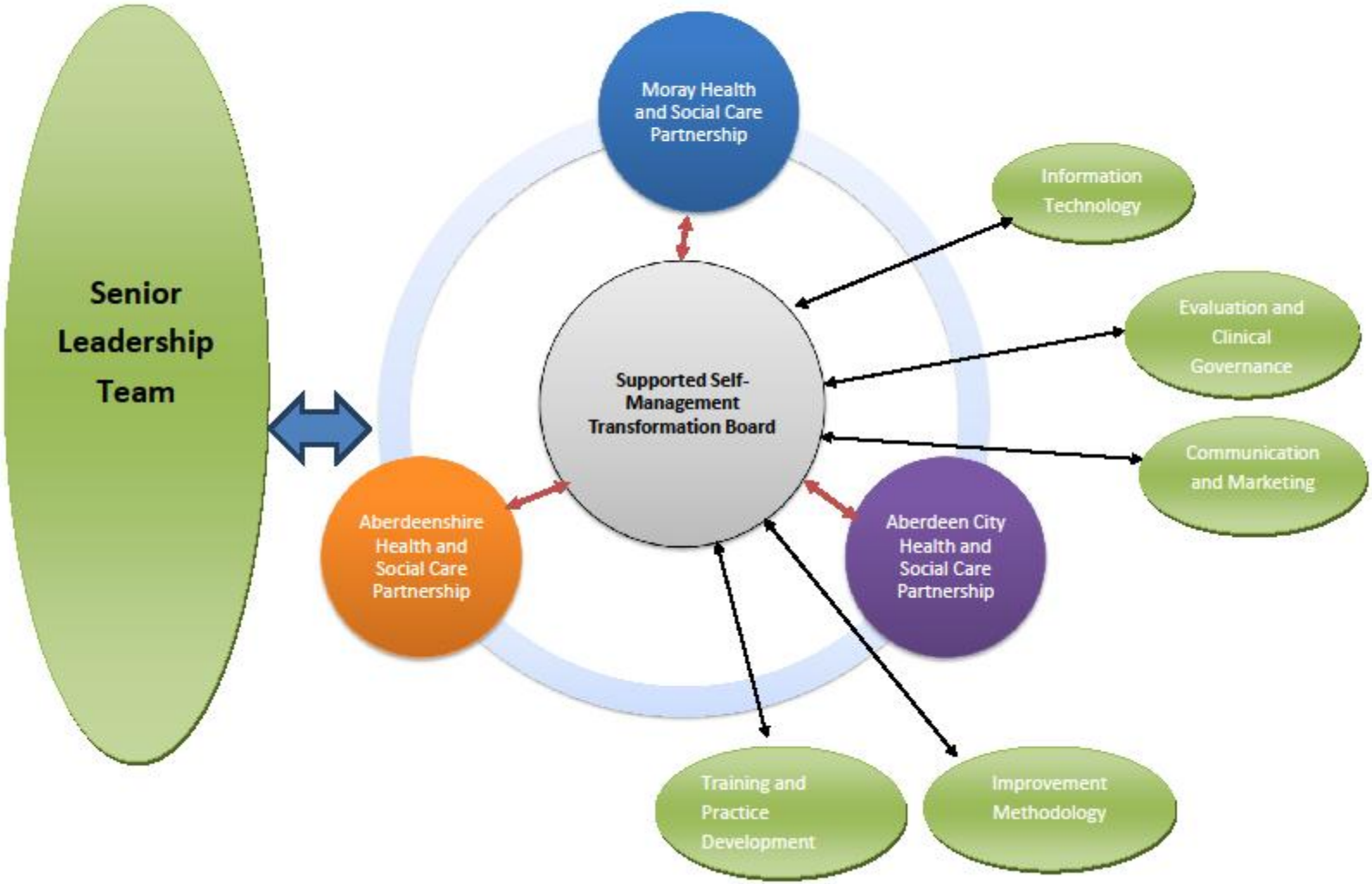
- Moray Health and Social Care Partnership (HSCP) Strategic Planning and Commissioning Group
- Aberdeenshire HSCP
- Aberdeen City HSCP

Agenda and Minutes – administrative support will be provided by NHS Grampian Public Health, and agendas and minutes will be circulated electronically in advance of each meeting.

Working groups – working groups will be required on a task and finish basis:

- Training and practice development
- Communications and marketing
- Improvement methodology
- Evaluation and clinical governance
- Local HSCP transformation groups

Grampian Clinical Strategy Supported Self-Management Transformation Programme Board



Addendum

1. Strategic Context

The national self-management strategy was published by the Scottish Government and the Health and Social Care Alliance (www.alliance-scotland.org.uk) in 2008, and remains in force.[1] The strategy highlights the importance of collaboration and participation, with self-management being the result of services helping a person 'to live well' in the presence of long-term conditions.

The Christie Commission and subsequent associated legislation 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. The National Clinical Strategy for Scotland repeatedly highlights clinical services' role in supporting self-management, [2] and the Grampian Clinical Strategy contains Supported Self-Management as one of its four strategic themes.

NHS Grampian 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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[1] www.gov.scot/Publications/2008/10/GaunYersel
[2] www.gov.scot/Publications/2016/02/8699
[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

Addendum

2. 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 include diabetes, asthma, depression, coronary heart disease, and chronic obstructive pulmonary disease. 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. 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 have 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.

Supporting self-management is a fundamental component of the move to develop person-centred health and social care services.[7] 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 that their current health condition poses to that, 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.

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

Addendum

3. Vision

Multi-disciplinary and multi-agency workshops in advance of the Grampian Clinical Strategy helped articulate four core concerns for delivering supported self-management in Grampian.

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

Equal attention must be paid to 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,[8] professionals often have to work 'despite the system' to achieve this.

*2. 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. Helping people to help themselves 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. Improving health literacy and optimising patient activation are important endeavours.

4. Resources and tools

A wide range of resources are available to help people to self-manage, including analogue and digital resources, digital communication technologies, and telehealth devices and telephone services.

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

Addendum

4. Implementation

It is proposed that the Transformation Programme Board adopt *House of Care* as the overarching model for the development of systems to support self-management in Grampian. A Project Initiation Document has been drafted.

It is recognised that multiple service developments that could potentially support self-management are being undertaken across health and social care systems in Grampian. The intention is not to co-opt them all under *House of Care* – rather, the model provides a strategic framework within which those leading such developments can locate themselves. This will allow for improved communication and collaboration between different developments and will provide assistance to strategic planning and commissioning groups in identifying potential areas of duplication and relative neglect.

House of Care is fully consistent with the vision developed for the Grampian Clinical Strategy, and is supported by the Health and Social Care Alliance[9], by Scottish Government[10], and learning is available from its implementation elsewhere in Scotland[11] and the UK[12].

At the centre is the conversation between the person and their healthcare professional

The left wall is an empowered person

The right wall is a commitment to partnership working

The roof is made of organisational processes

The foundations are the wider sources of support that are available to the person

Colleagues from Public Health and the Diabetes MCN have established good working relationships with the Alliance, Scottish Government and other health board areas who are involved in *House of Care.* The national *House of Care* executive group allows for the sharing of learning across Scotland. Public Health have identified funding to commissioning initial training and in-practice organisational development from *Year of Care*, the NHS provider supporting *House of Care* in England and the other Scottish Health Boards.

[9] www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/scotlands-house-of-care/
[10] www.gov.scot/Publications/2016/02/8618/7
[11] www.alliance-scotland.org.uk/scotlands-house-of-care-review-of-2016
[12] https://www.yearofcare.co.uk/year-care-solution