Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 8 June 2016

Subject: Manchester's Self Care Strategy

Report of: David Regan, Director of Public Health

Summary

This covering report summarises Manchester's Self Care Strategy and the actions required to enable self care. The Strategy has been developed by a wide range of stakeholders in the City and is integral to the delivery of a number of Transformation Programmes contained in the Manchester Locality Plan. The delivery of the Strategy will be one of the key Phase One activities under Our Manchester.

Recommendations

The Board is asked to approve the Self Care Strategy

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The aims of the Self Care Strategy are to 1. Enable people to access, understand and use the information they need to care for and support their own health and wellbeing. 2. Enable people to identify lifestyle changes and goals for themselves, improving their physical and mental wellbeing and preventing ill-health 3. Facilitate collaborative decision making between people with physical and mental long term conditions, their carers and the teams that work with them. **4.** Facilitate the changes in the system required for enabling self care
Improving people's mental health and wellbeing	
Enabling people to keep well and live independently as they grow older	
One health and care system – right care, right place, right time	
Self-care	

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Supporting People in Manchester to be Active Partners in Caring for their Health: Manchester's Strategy for Enabling Self Care 2015-2020

1. Introduction

1. The detailed strategy (see Annex 1) encompasses the actions that will be required to enable self care in the broadest sense. A self care approach will be integral to the transformation of community based health and social care in Manchester – One Team. It also forms part of transformation priority 1 – 'The Public's Health' of Manchester's Locality Plan and is a priority for the Health and Wellbeing Strategy.
2. The strategy has been co-produced with professionals and practitioners from a range of agencies and the public. Events were held that brought together patients, carers and service providers from across the public, voluntary and community sectors to identify the actions required to enable self care. Expertise in psychology and behaviour change from academic partners informed the model of change for the City.
3. The strategy is also underpinned by the research evidence base for supporting self-management for people with long-term conditions.
4. This summary paper provides the Health & Wellbeing Board with an overview of the Strategy and going forward the delivery of the Strategy will be a key element of the emerging Our Manchester approach.

2. Key Issues

2.1 What is self care?

Self care is what we do for ourselves to stay healthy and look after our wellbeing. It is something that we all do. It includes the choices we make to prevent illness such as eating healthy food, having a flu vaccination, doing exercise and getting enough sleep. It also includes the actions we take to manage minor illness such as coughs and colds. When people have long-term conditions such as diabetes or asthma, they make decisions about how to manage their conditions themselves every day.

2.2 What do we mean by enabling self care?

Improving self care requires greater personal responsibility for health and wellbeing. People should be supported to take control of their own health and focus on what changing ***what matters to them***. This support comes from informal carers, and the organisations and practitioners who provide health and social care. The essence of this support is a ***collaborative trusted relationship*** between people (service users) and practitioners (service providers)

2.3 How can we enable self care?

We need an organisational approach accross the City that empowers a person to play a central role in the planning and implementation of their care. In Manchester we call this the ***Self Care Approach.*** In order to enable self care, the approach of health and care practioners and providers needs to be;

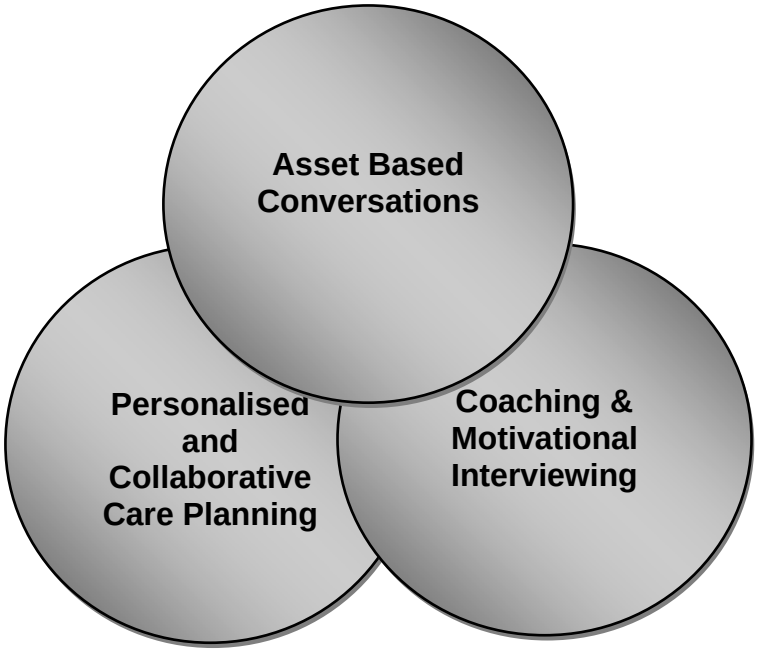
- **Personalised**- focussed on what matters to the person (person's goal).
- The practitioner helps the person to articulate and specify their wishes and develop a practical means of working towards them.

- **Asset based**- recognises strengths and abilities (assets) not just illness and problems (deficits).
- The practitioner works with the person to identify their assets including; their attitude, skills and knowledge, carers, social support and resources. These assets are used as the basis of joint plans.
- **Relational**- based on trust, understanding, empathy and emotional connection, not just the 'transaction' or episode of care. This trust can only be developed over a period of time.
- **Holistic** - services form a sophisticated understanding of a person's particular context, taking their social circumstances into account and addressing these in order to achieve their goals.
- **Collaborativ**e – plans are developed jointly between the practitioner and the person they are supporting.

It should also take account of people's level of **health literacy;** this is the resources individuals need to access, understand, appraose and use information and services to make decisions about their health.

2.4 How does this link to Our Manchester and an asset based approach?

An asset based approach is fundamental to enabling self care. As can be seen from the principles above, organisations and frontline practitioners will need to form a new relationship with the people they work with to enable self care. This requires large scale cultural and behavioural change. The skills-set and behaviours required can be broadly summarised as displayed below.



2.5 Why do we need a self care approach?

Manchester people have some of the poorest levels of ill health, morbidity and early mortality rates in England. This has many consequences including poor quality of life for residents, worklessness and high demand for health and social care service

Over 90% of people with long term conditions nationally say they are interested in being more active self managers, and over 75% would feel more confident about self management if they had help from a healthcare professional or peer. Despite this, many people with long term conditions have limited knowledge of, or influence over their care. Reports also suggest a lack of engagement by people in consultations evidenced by failure to attend follow-up appointments, poor uptake of patient education and a large percentage of prescribed medication for long term conditions that is not taken. These will be associated with poor outcomes for patients at greater cost to the health care system.

The three Manchester CCGs have high levels of unplanned hospital admissions. Ambulatory care sensitive conditions are those conditions for which hospital admission can be avoided through outpatient treatment or preventive measures. The Manchester CCGs rank 195th (Central), 196th (South) and 199th (North) out of the 211 CCGs in England for unplanned hospital admissions for ambulatory care sensitive conditions.

In addition to this, the population is growing and ageing whilst healthcare budgets are decreasing. It has been predicted that between 2010 and 2018, age-adjusted spending per person on the NHS will have dropped by 9%. Focussing on prevention and addressing the underlying causes of health is increasingly important in this context. Changes to the way we look after ourselves, and each other, are essential to support the sustainability of the healthcare system.

2.6 What are the Benefits?

A self care approach to health and social care is expected to have three main benefits;

- Empowering patients – people will be encouraged to participate as equal partners in decisions about their care. This gives people an opportunity to take control of their health and wellbeing rather than health professionals being in control
- Improving outcomes- When people self care and are effectively supported to this, they are more likely to:
  - Experience better health and well-being
  - Reduce the perceived severity of their symptoms, including pain
  - Improve medicines compliance
  - Prevent the need for emergency health and social services
  - Prevent unnecessary hospital admissions
  - Have better planned and co-ordinated care
  - Remain in their own home
  - Have greater confidence and a sense of control
  - Have better mental health and less depression

- Managing Demand-- although not the primary reason for supporting self care, this is an important added benefit. The department of health estimates that 15% of A&E attendances and 40% of GP time could be avoided. Over two-thirds of GP visits result in prescribing drugs that are available over the counter. The Wanless review (2002) estimated that for

every £100 spent on helping patients care for themselves, £150 could be saved by the reduction of GP and outpatient visits. Potential benefits for the health and social care system could include;

- Improved patient satisfaction
- Reduced visits to GPs
- Reduced hospital admissions
- Decreased number of days in hospital
- Reduced outpatient visits
- Reduced A&E visits
- Reduced medication expenditure
- Improved medication compliance

3. The Strategy

1.1 Vision & Aims

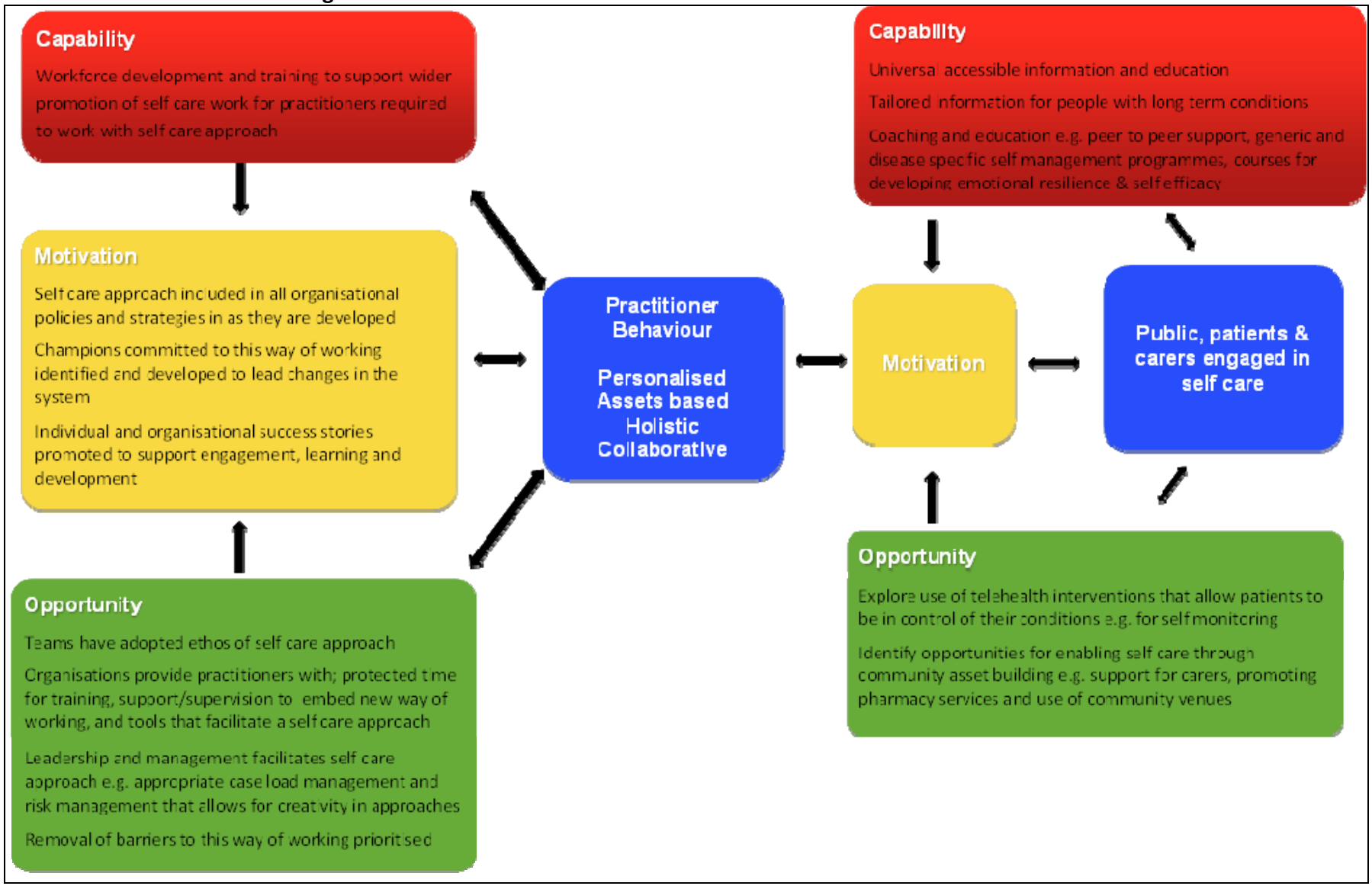
Our vision is that “People in Manchester are active partners in the management of their health and wellbeing, to live longer and better lives”
Our aims are to:

- Enable people to access, understand and use the information they need to care for and support their own health and wellbeing.
- Enable people to identify lifestyle changes and goals for themselves, improving their physical and mental wellbeing and preventing ill-health
- Facilitate collaborative decision making between people with physical and mental long term conditions, their carers and the teams that work with them.
- Facilitate the changes in the system required for enabling self care

3.2 Model of change

This is illustrated on the following page. It incorporates the organisational and system changes required to deliver the self care approach. All changes in behaviour are underpinned by ***capability, motivation and opportunity***. These need to be addressed for practioners to deliver a self care approach. They also need to be addressed for the public, patients and carers to engage in self care. Finally activities that focus on promoting system-wide action will be required to deliver the self care approach.

The Manchester Model of Change for Self Care



3.3 Workforce development and training

This is one of the key activities that will be delivered and in order to embed these approaches and enable cultural change across the system, there will be a number of other requirements including but not limited to;

- A framework for embedding new approaches that includes protected time for training, embedding self care in induction and appraisal processes, supervision and peer support
- Leadership and management styles that support this approach. Managers need to support practitioners in changing their practice; our training evaluations showed that management styles can be a barrier because they were target driven and lacked understanding of self care approaches. Coaching styles, personalised care-driven supervision, positive risk taking versus risk averse risk management and appropriate case load management can all support practitioners to use a self care approach. Briefing and training for managers and leaders is therefore essential.
- Removal of other barriers should be prioritised such as introducing patient information recording systems that are suitable for self care approaches e.g. how can you record a “spider diagram” and record person centred plans in person centred language?
- Further development of performance measures that capture outputs of self care without influencing the dynamics of a consultation.
- Consideration of how other frontline staff that people come into contact with influences this approach e.g. are home care staff and staff in residential nursing homes using approaches that support this agenda?
- Training, education and information for the public, patients and that reflects best practice in coaching and self efficacy, peer to peer support and self management programmes such as the Expert Patient Programme. Information should be given in an accessible format that takes health literacy into account.
- The use of assistive technology in enabling self care.

3.4 Measuring Progress

The Health and Wellbeing strategy outcomes framework incorporates self care. As part of Transformation Priority 1 of Manchester’s locality plan, outcome measures that specifically capture the transformation required to deliver the self care approach are being developed. This will form part of the evaluation for this programme of work.

4. Recommendations

The Health and Wellbeing Board is asked to approve the strategy for Manchester.

Supporting People in Manchester to be Active Partners in Caring for their Health
Manchester's Strategy for Enabling Self Care 2016-2020

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1 Introduction

1.1 What is Self Care?

Self care is what we do for ourselves to stay healthy and look after our wellbeing. It is something that we all do. It includes the choices we make to prevent illness such as eating healthy food, having a flu vaccination, doing exercise and getting enough sleep. It also includes the actions we take to manage illness when we are unwell for example visiting the pharmacy for coughs and colds. When people have long-term conditions such as diabetes or asthma, they make decisions about how to manage their conditions themselves every day.

Improving self care requires greater personal responsibility for health and wellbeing. People should be able to take control of their health, and focus on changing what matters to them. To do this well, people need support from carers and the organisations and practitioners who provide health and social care. The essence of this support is a collaborative relationship between people (service users) and practitioners (service providers).

Self care has also been described as a continuum that encompasses self care, self management and shared care. The level of support required from health and care services increases as you move along the continuum. This is shown in the diagram below.

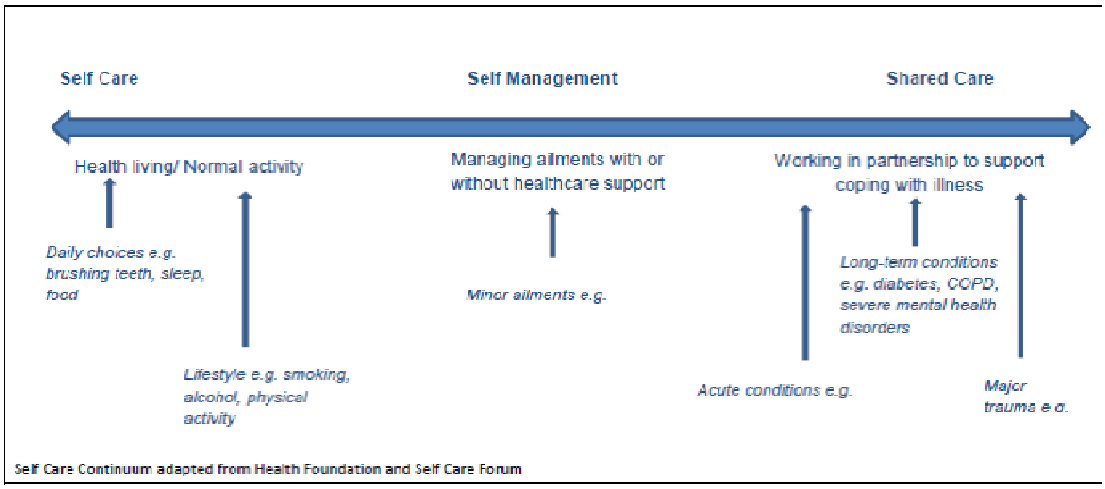


Figure 1. Continuum of self care (adapted from Health Foundation and Self Care Forum)

1.2 How Can We Enable Self Care?

In order to enable self care, we need an organisational approach that empowers a person to play a central role in the planning and implementation of their care.

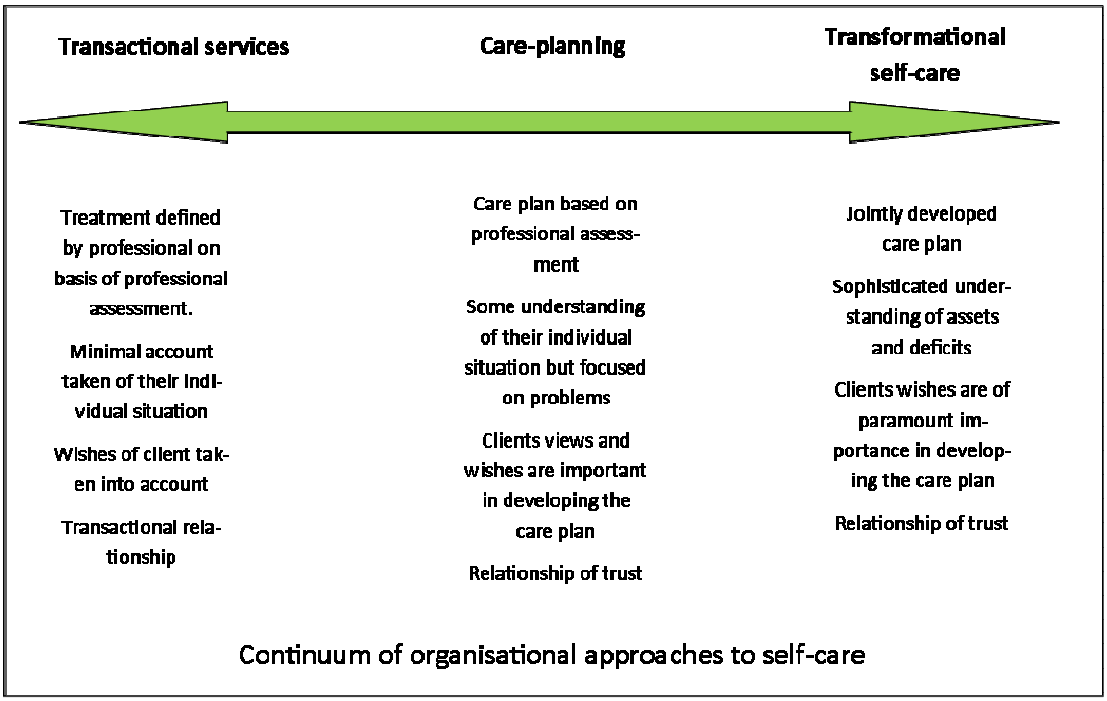


Figure 2. Organisational approaches to self care

This approach will require people to alter what they do i.e. change their behaviour. Health and social care providers and practitioners will have to change how they work in order to deliver a service that promotes and supports self care. This will support behaviour change among the public (e.g., changing behaviours that lead to prevention of disease) and patients (e.g., changing behaviours associated with management of long term illness).

An understanding of theories of behaviour change will, therefore, support the transition to increasing self-care. There are over 80 theories of behaviour change so it is crucial to have a simple framework. The Behaviour Change Wheel, described by Mitchie and colleagues, is an evidenced based framework that helps us to understand behaviour change among the public, patients and staff. Central to the Behaviour Change Wheel is the idea that an individual's behaviour is governed by their ***capability, opportunity*** and ***motivation***.

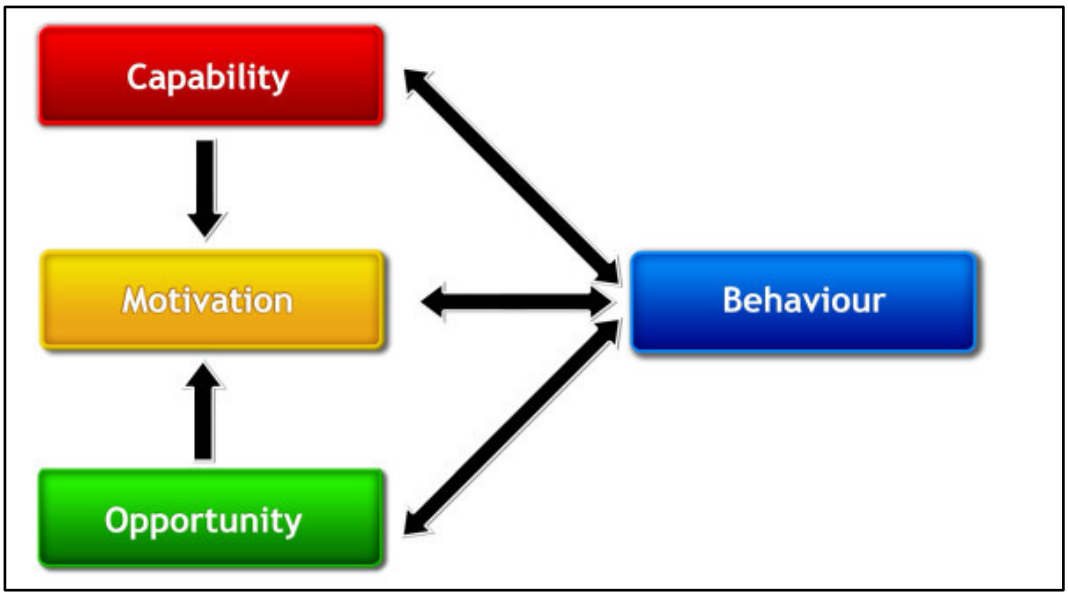


Figure 3. The COM-B system- a framework for understanding behaviour (Mitchie et al 2011)[1]

If we want to change behaviour, we need to understand;

- Motivation -how people ***think and feel about the new behaviour*** (reflective motivation) and whether they can ***adopt the behaviour into habit*** (automatic motivation).

  For example practitioners receiving incentives to change their approach and the tools for adopting the new approaches into habit.

- Capability-whether they have the ***knowledge*** (psychological capability) and the ***skills*** (physical capability) to carry out the new behaviour.

  For example practitioners gaining the knowledge and set of skills required to carry out a self care approach, including a high level of communication skills and behavioural change techniques.

- Opportunity-whether ***people around them*** will 'allow' them to conduct the new behaviour (social opportunity) and whether ***the system / environment*** in which they work or live will allow them to conduct the new behaviour (physical opportunity)

  For example practitioners working in teams that have adopted the ethos and practices of a self care approach, with manages that provide the leadership to make the approach feasible, and organisations that provide them with the training and other necessary resources to carry out this approach.

[1] . Michie S, van Stralen MM, West R. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implement Sci 2011;6:42.

1.3 The Self Care Approach

In order to support and enable self care the approach of health and care practitioners and providers needs to be;

- Personalised- focussed on what matters to the person (person's goal).

  The practitioner helps the person to articulate and specify their wishes and develop a practical means of working towards them.

- Asset based- recognises strengths and abilities (assets) not just illness and problems (deficits).

  The practitioner works with the person to identify their assets including; their attitude, skills and knowledge, carers, social support and resources. These assets are used as the basis of joint plans.

- Relational- based on trust, understanding, empathy and emotional connection, not just the 'transaction' or episode of care. This trust can only be developed over a period of time.

- Holistic - services form a sophisticated understanding of a person's particular context, taking their social circumstances into account and addressing these in order to achieve their goals.

- Collaborative – plans are developed jointly between the practitioner and the person they are supporting.

It is also important for the approach to take account of people's ***health literacy***; this has been defined as "the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health" (WHO). Health information in circulation nationally is currently too complex for 43% of working age adults to understand. This increases to 63% if numerical information is included. Any information (verbal and written) provided as part of the self care approach, needs to be accessible for the person using it.

My patient Journey by Sharon C (BD 3191)

8 years ago I got diagnosed with meningioma grade 1 brain tumour & epilepsy in those 8 years I have had to try manage my symptoms on my own, because every operation I have had I never got aftercare so I didn't know any different.

My last operation was in 2012 this one nearly pushed me over the edge because my condition was getting worse, yet still with no aftercare. I couldn't cope in my life; I went to doctors numerous times for help only to be given more tablets. In 2013 I went back to doctors asking for help again, she told me about going to groups, so I tried 2 types of groups but they were not for me. I went back in 2014 and explained to my doctor that I can't cope, so she mentioned trying the Expert Patients Programme (EPP).

In my mind this was going to be my last chance to try help myself, "if this group isn't for me I'm going to finish my life". That's how low I felt in my life. The end of June 2014 I not only found out about EPP I found faith too.

When I arrived at the course, I was made to feel very welcome and comfortable, which helped me to give it a try, by the end of session I had poured my heart out the tears were running down my face, I couldn't believe I had just released so much pain and hurt stress in front of total strangers.

From then I didn't miss one week. I started to get somewhere slowly but surely I something out of EPP every week. I started to learn about the toolbox to help break down symptoms as I have experienced every one of those on that symptom cycle chart displayed. I couldn't believe my eyes this course was for me. When the 6 weeks finished I thought to myself what I am going to do as I really got a lot from EPP.

The most important thing is I got good after care from this service, I learnt how to manage my condition using the tools shared on the course which included how to work with the doctors to manage my condition, sharing information that helps us decide how my care is delivered in a way I can follow.

EPP has helped me a lot and in my heart I know it will help so many people from all walks of life.

Thank you

1.4 Why Do We Need a Self Care Approach?

Manchester people have some of the poorest levels of ill health, morbidity and early mortality rates in England. This has many consequences including poor quality of life for residents, worklessness and high demand for health and social care service.

There are 150,000 people registered with a Manchester GP who have at least one long term condition; that is 25% of registered population. These conditions include high blood pressure, depression, diabetes, asthma and heart disease. The number living with long term conditions is expected to rise.

Over 90% of people with long term conditions nationally say they are interested in being more active self managers, and over 75% would feel more confident about self management if they had help from a healthcare professional or peer. Despite this, many people with long term conditions have limited knowledge of, or influence over their care . Reports also suggest a lack of engagement by people in consultations evidenced by failure to attend follow-up appointments, poor uptake of patient education and a large percentage of prescribed medication for long term conditions that is not taken. These will be associated with poor outcomes for patients at greater cost to the health care system.

The three Manchester CCGs have high levels of unplanned hospital admissions. Ambulatory care sensitive conditions are those conditions for which hospital admission can be avoided through outpatient treatment or preventive measures. The Manchester CCGs rank 195th (Central), 196th (South) and 199th (North) out of the 211 CCGs in England for unplanned hospital admissions for ambulatory care sensitive conditions.

In addition to this, the population is growing and ageing whilst healthcare budgets are decreasing. It has been predicted that between 2010 and 2018, age-adjusted spending per person on the NHS will have dropped by 9%. Focussing on prevention and addressing the underlying causes of health is increasingly important in this context. Changes to the way we look after ourselves, and each other, are essential to support the sustainability of the healthcare system.

1.5 What are The Benefits?

A self care approach to health and social care is expected to have three main benefits; empowering patients, improving outcomes and managing demand.

1. Empowering patients – people will be encouraged to participate as equal partners in decisions about their care. This gives people an opportunity to take control of their health and wellbeing rather than health professionals being in control

2. Improving outcomes – the best evidence for improving outcomes is in supporting self management for long term conditions. The most important aspect of this is the effectiveness of consultations between patients and clinicians. When people self care and are effectively supported to this, they are more likely to:

- Experience better health and well-being
- Reduce the perceived severity of their symptoms, including pain
- Improve medicines compliance
- Prevent the need for emergency health and social services
- Prevent unnecessary hospital admissions
- Have better planned and co-ordinated care
- Remain in their own home
- Have greater confidence and a sense of control
- Have better mental health and less depression

3. Demand management - although not the primary reason for supporting self care, this is an important added benefit. The department of health estimates that 15% of A&E attendances and 40% of GP time could be avoided. Over two-thirds of GP visits result in prescribing drugs that are available over the counter. The Wanless review (2002) estimated that for every £100 spent on helping patients care for themselves, £150 could be saved by the reduction of GP and outpatient visits. Potential benefits for the health and social care system could include;

- Improved patient satisfaction
- Reduced visits to GPs
- Reduced hospital admissions
- Decreased number of days in hospital

- Reduced outpatient visits
- Reduced A&E visits
- Reduced medication expenditure
- Improved medication compliance

1.6 What does this strategy cover?

Self care approaches will be integral to the transformation of community based health and social care in Manchester -One Team/Living longer, Living Better, and the other transformation programmes within the Manchester Locality Plan -Our Healthier Manchester.

This strategy encompasses actions that will be required to enable self care in the broadest sense, for both the prevention and management of ill health. There is a strong focus on the system of organisations, service providers and practitioners. This is because of the change is required in the behaviours that make up the way we currently deliver health and social care, in order to deliver a self care approach. These behaviours are underpinned by attitudes, cultures, current practices and structural or organisational design.

People of all ages who live in Manchester are included; however different people will need different levels of support to self care. The basic level of support offered increases along the self care continuum and aligns with the stepped care model for One Team service delivery as shown in the diagram below.

The actions identified within this strategy have been co-produced with professionals and the public. Events were held that brought together patients, carers and service providers from across the public, voluntary and community sector to identify what needed to be introduced, developed or stopped across the system to enable self care. Co-production is part of the philosophy of self care, and this approach will continue to be used as detailed plans are developed and implemented.

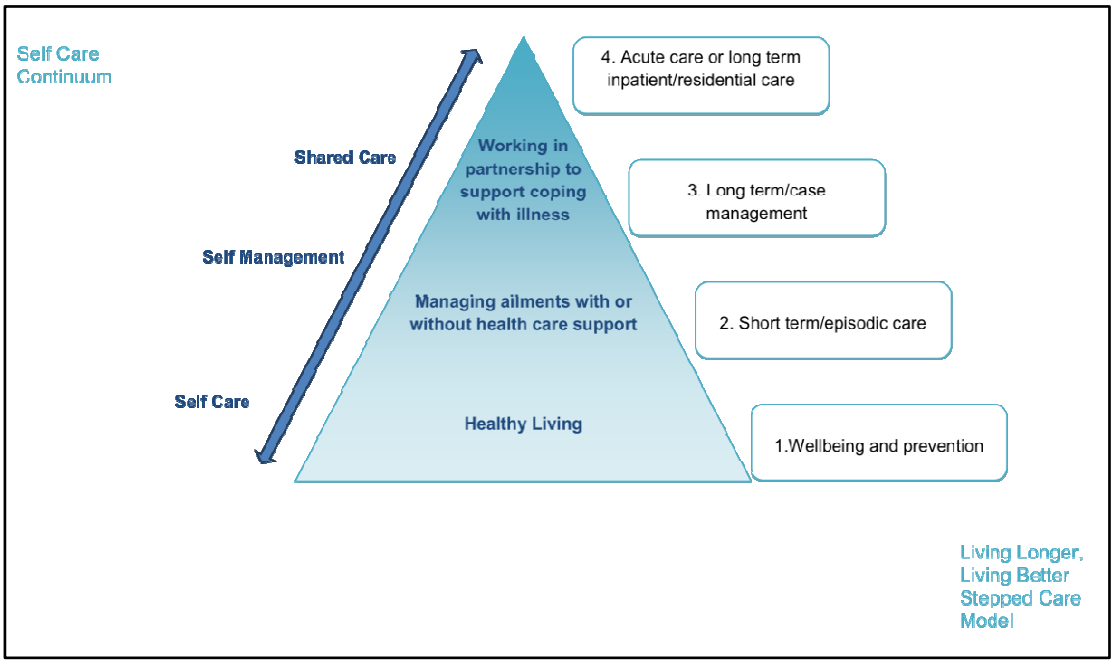


Figure 4. Self care continuum and stepped care model for Living Longer, Living Better. This is purely for illustrative purposes; self care encompasses self management and shared care.

2 Where are we now?

2.1 Strategic Context

Manchester's Joint Health and Wellbeing Strategy describes a vision for the health and wellbeing of its residents to live longer, healthier and more fulfilled lives over the next ten years. Self care is one of the strategic priorities that will deliver this vision as part of the focus on prevention and transformation of health and social care. As such, self care is also integral to The Manchester Locality Plan and One Team (Living Longer, Living Better). The Manchester Carers Strategy also priorities self care.

"Our Manchester" is the working title for a citywide asset based approach that is being developed in Manchester; examples include training in strengths based conversations for Early Help staff, community strengths based tools being developed for the behaviour change programme, and motivational interviewing skills used as part of the Working Well programme. This approach is a fundamental part of self care, and the broader agenda will support the transformation required across the system.

Finally self care has been recognised as a priority for national health care policy and system reform. It is a central to the health and social care integration agenda and transformation of services that is taking place at a large scale across the country. The Five Year Forward View vision for the development of the NHS places an emphasis on prevention of ill health, and the need to empower individuals and communities to have greater control over their health.

2.2 Self Care activity across Manchester

There are several examples of activity for supporting self care that have been taking place across the city, some of these are described below.

Enabling Self Care training course

In North Manchester, 202 health and social care practitioners (including 13 active case managers, 22 social care practitioners 24 GPs, 9 administrators and 16 practice managers) have completed self care training since 2013. Training has been provided on a smaller scale in other areas of the city. 93% of 106 participants that had been trained by March 2014 reported an increase in confidence about enabling self care as a result of the training. The elements that participants found most useful were; using scaling to support behaviour change, communications skills and tools to support conversations about self care and an improved understanding of enabling self care.

North Manchester Integrated neighbourhood Care' (NMINC)

One of the main drivers for NMINC model focuses on embedding enabling Self Care concepts. This is being achieved by;

i) Training all members of staff that are key workers and offering continual support for staff through Enabling Self care forums. These forums are supported by the health and wellbeing 'Enabling Self care' trainer and by professional themselves. It provides an opportunity to explore what enabling self care really is and how to embed the tools and techniques into everyday practice. The Forums are attended mainly by active case managers and social workers, and this is being acknowledged in the care they are giving.

ii) The model is also supported by an integrated care record, Graphnet, which has the support/care plan for NMINC. This care plan is based around enabling self care (what is important to the person) as well as self management (continual management to prevent deterioration and crisis) and crisis plans (what to do if you are in a crisis). Having a care plan with a self care focus helps practitioners to keep focused on enabling self care.

iii) The keyworker and person use a tool called the Patient Activation Measure (PAM). This tool allows conversations to start around enabling self care and show's how ready or “activated” the person is to self care. This helps to plan care and help motivate people especially around what is important to the person. This tool also allows us to monitor self care improvements by giving the person an activation score at the beginning and at the end of care.

A recent audit of self care plans demonstrated that the techniques and concepts delivered in the training are being implemented in practice. This is also being reflected in the case studies that are being collated.

Expert Patients Programme (Living well with a long term condition)

The Expert Patients Programme (EPP) is delivered by UHSM (University Hospital of South Manchester) across the city of Manchester. The programme offers weekly sessions for 6 weeks in community settings, to help participants gain the self confidence to manage the symptoms related to living with health conditions. It supports people who live with long-term health conditions take a positive role in managing the non-clinical aspects of their health and well-being. Self care has a key role to play in supporting people to live better for longer.

It builds on the principal that people who live with long-term health problems know best how their condition affects the way they feel on a day to day basis, their lifestyle and ability to accomplish activities important to them. The course also looks at ways to positively manage symptoms and changing emotions that can be brought about by living with long-term health conditions. The UK and international evidence into the effectiveness of the programme has been excellent; EPP is the leading self-management/self-care programme in the UK.

A patient who recently attended the course locally said:

> "The most important thing is I got good after care from this service, I learnt how to manage my condition using the tools shared on the course which included how to work with the doctors to manage my condition, sharing information that helps us decide how my care is delivered in a way I can follow". BD Patient number 3191

South Manchester CCG – Newall Green self care project

This project involves close working with housing partners to better use collective resources to develop local self care and volunteer opportunities across South Manchester, starting with a pilot scheme in Newall Green. This includes establishment of self care groups, volunteer capacity, and the formation of a 'Timebank' in Wythenshawe. This will be the second Timebank in the UK to have a focus on supporting patients at a General Practice setting. The aim is to reduce social isolation, improve support networks and resilience within communities. The project also focuses on supporting people who are out of work, people from new and emerging communities and new entrants to the country (the local GP reports isolation amongst new and emerging communities in Wythenshawe) and people who are socially isolated. The service will help people to better engage with a vibrant local voluntary and community sector, to learn new skills through peer support, and re-establish confidence for people in an area of Manchester which experiences high levels of deprivation and unemployment.

Manchester Community Health Trainers Case Study 2014

Catherine 48 and from Crumpsall started accessing the Health Trainer Service in December 2013. She explains how she has maintained changes which were kick started by support from Health Trainer Stephen Hoy.

Catherine first saw Health Trainer Stephen Hoy back in December 2013. She found out about the Health Trainer Service via her GP surgery at Park View Medical Centre. At the time Catherine wanted some support as she was suffering from low mood and feeling down a lot of the time and was not going out much. She also wanted to lose some weight.

She met with Stephen at her house for the initial appointment. Catherine had stopped going out as much and had also stopped the volunteering work she used to do and really enjoy. By talking through how she felt and what she wanted to do with Stephen, Catherine feels like she built her confidence back up enough to set small goals. This then eventually led to her main goal of getting back to volunteering. This enabled her to get out more and to improve her mood.

Additionally Stephen gave her tips on healthy eating to address her goal of wanting to lose some weight. For example one of the goals was to start eating breakfast every day which she never used to do. This has given her more energy and also contributed along with other changes to her achieving a weight loss of over 2 stone since working with Stephen. This was one of the key goals she had in mind and is very happy she has lost some weight and has also managed to maintain this weight loss.

Following on from getting back to volunteering and building her confidence Catherine then joined a walking group and started attending Zumba. This has also led onto her learning to cycle via sessions run by Manchester Transport Group which she found out about from one of the walkers at the walking group.

Catherine feels that Stephen helped her to realise the things she wanted to do were achievable and gave her the confidence to do them. By having someone alongside her who was approachable and supportive made a big difference. She would recommend the service to someone wanting to make similar changes.

3 What do we want to achieve?

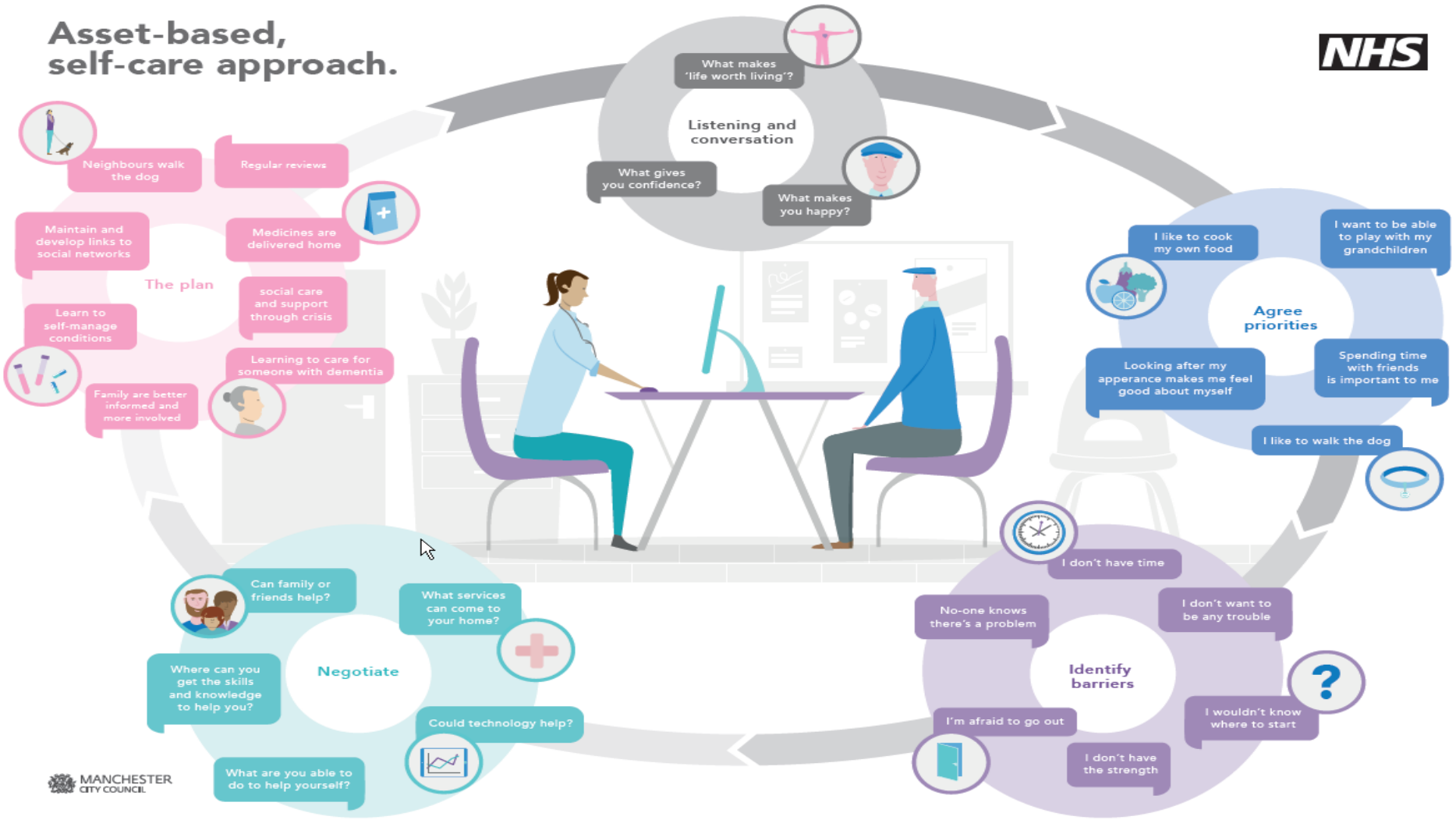
3.1 Vision

Our vision is that ***"People in Manchester are active partners in the management of their health and wellbeing, to live longer and better lives"***

Our aims are to:

1. Enable people to access, understand and use the information they need to care for and support their own health and wellbeing.
2. Enable people to identify lifestyle changes and goals for themselves, improving their physical and mental wellbeing and preventing ill-health
3. Facilitate collaborative decision making between people with physical and mental long term conditions, their carers and the teams that work with them.
4. Facilitate the changes in the system required for enabling self care

Evidence suggests that the key factor influencing people to self care is the relationship they have with practitioners. Practitioners that have the skills to deliver a self care approach are therefore central to the transformation that is required.


Asset-based, self-care approach.
NHS
What makes 'life worth living'?
Listening and conversation
What gives you confidence?
What makes you happy?
Neighbours walk the dog
Regular reviews
Maintain and develop links to social networks
Medicines are delivered home
The plan
social care and support through crisis
Learn to self-manage conditions
Learning to care for someone with dementia
Family are better informed and more involved
I like to cook my own food
I want to be able to play with my grandchildren
Agree priorities
Looking after my apperance makes me feel good about myself
Spending time with friends is important to me
I like to walk the dog
Can family or friends help?
What services can come to your home?
Negotiate
Where can you get the skills and knowledge to help you?
Could technology help?
What are you able to do to help yourself?
I don't have time
No-one knows there's a problem
I don't want to be any trouble
Identify barriers
I'm afraid to go out
I wouldn't know where to start
I don't have the strength
MANCHESTER CITY COUNCIL

4 How will we achieve it?

4.1 Model of Change

The model of change that has been developed for Manchester is illustrated on the following page. It incorporates the organisational and system changes required to deliver the self care approach, and summarises the objectives that will deliver our aims.

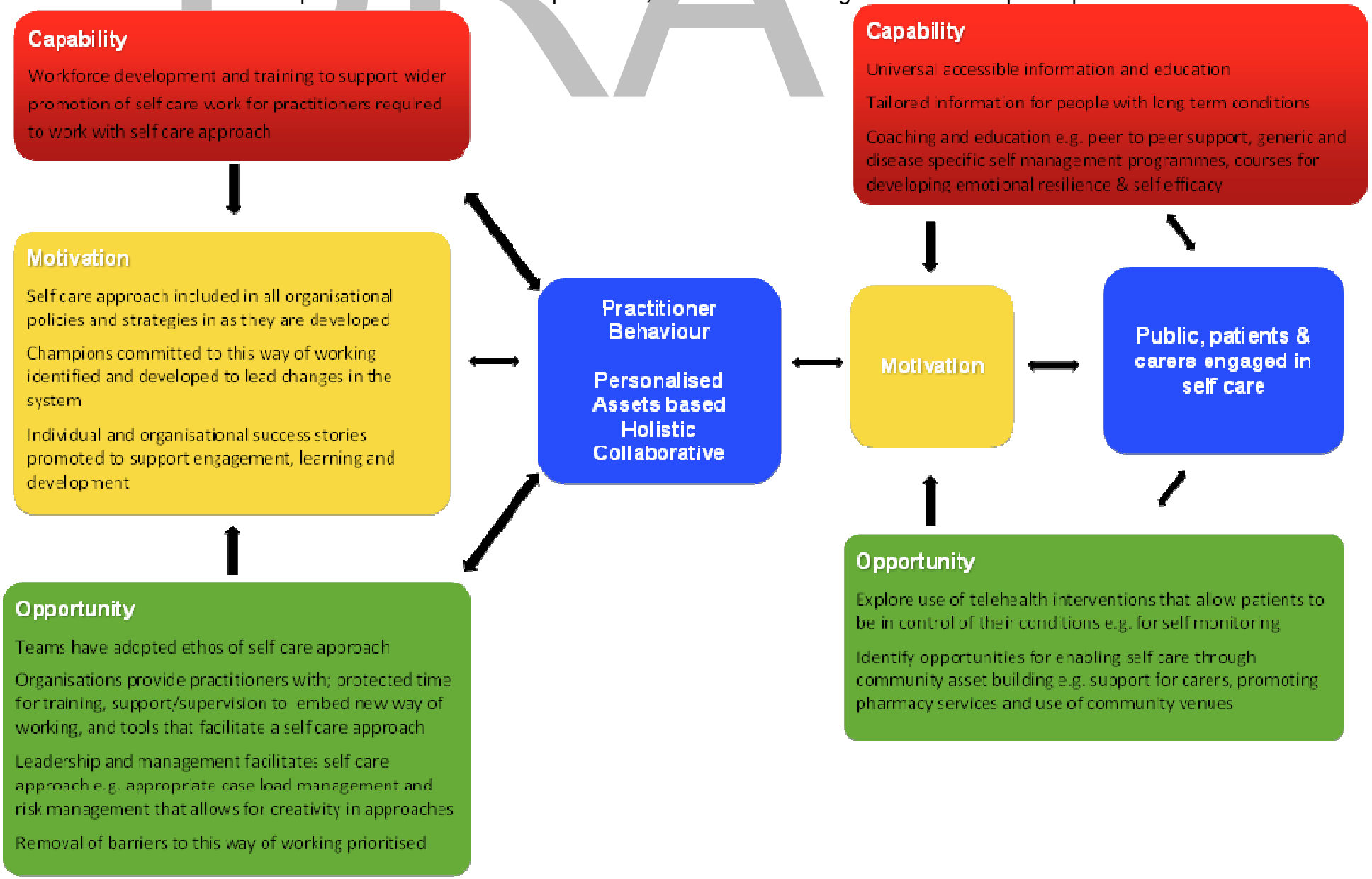
To the left of the model are the objectives that govern practitioners' capability, motivation and opportunity to deliver a self care approach. To the right of the model are those objectives, in addition to the practitioner focussed list, that will enable patients and carers to engage in self care. A detailed list of objectives for 2015 to 2020 is given in the appendices.

Three groups of activities have been identified that will be required to achieve these objectives:

1. Activities with a focus on service providers (including public sector, voluntary and community sector and informal carers)
2. Activities with a focus on the public and patients
3. Activities with a focus on promoting system-wide action on self care

The activities to enable self care and promote healthy living at the lowest tier of the stepped care model should allow all residents to access some form of self care information and support. However specific groups will be targeted in line with local priorities, national recommendations for reducing health inequalities based on the life-course approach (Marmot), and the outcomes of Manchester's engagement events.

Manchester's model of change for enabling self care:
The boxes to the left focus on practitioners and service providers, the boxes to the right focus on the public patients and carers



Based on the COM-B framework for understanding behaviour (Mitchie et al 2011) – see page 6

4.2 Target Groups

The principle of proportionate universalism is about delivering universal services at a scale and intensity that is proportionate to the level of need. This is the approach described by Marmot, alongside the lifecourse approach, to reduce socially driven inequalities in health. All Manchester's residents should have access to support and information to enable self care as part of this strategy. In addition, specific groups have been identified for focussed activity. It will also be important to ensure that communities who are less likely to access universal support, or are particularly vulnerable or marginalised are targeted to ensure equity of service provision.

People with long-term mental or physical conditions

Rationale

- Burden of long-term conditions
- Strongest evidence base for self care is for self management of long term conditions
- Long term conditions and poor mental health have an impact on worklessness which is a key priority for the City.

Pregnant women and mothers[2] of pre-school children

Rationale

- Marmot review recommended emphasis on early years for reducing inequalities
- Self care messages from early childhood will have long term gains for prevention of ill health and cultural change
- Priorities for the City that will be addressed include school readiness, health of the unborn child, increasing unplanned hospital admissions for children and A&E attendances for children. Mothers may also be carers for older relatives.

Socially isolated

Rationale

- Priority in context of Age friendly Manchester and the ageing population, although not just an age-related issue

[2] Note that mothers have been identified for population level targeted activities because they are usually the primary caregiver and because of the impact on the health of the unborn child, but this will not exclude fathers and other guardians from activities at the individual case level.

- Social isolation as negative consequences for health and wellbeing, and social social connectedness is important for enabling self care

4.3 What are the risks?

The vision for health & social care services in Manchester, articulated in the LLLB Strategy, the 20220 Commissioning Specification, and the Manchester Locality Plan, is to create a new community based care system that achieves the following objectives:

- Improve health outcomes for the people of Manchester
- Improve service standards
- Ensure sustainable finances for the health and care system
- Support people in the City to be self reliant.

These objectives are interdependent, and it can be argued that the first three objectives are to a large extent dependant on the achievement of the fourth, which in itself will only be achieved if engagement with self care amongst Manchester residents increases significantly.

Therefore, there is a significant risk to the city's transformation aspirations if the self care strategy is not delivered.

Achieving the required levels of self care will require massive changes by the people of Manchester, that can only made possible by massive behavioural and cultural change among those responsible for providing health and social care. Key risks and barriers include:

For Manchester people:

- The sheer scale of the challenge
- Poor levels of health literacy
- High levels of deprivation and poor life chances which constrain people's ability to make healthy lifestyle choices and manage any long term conditions

For Manchester's health and social care staff

- A systematic change in ways of working, much of which can be paternalistic and focuses on "what's the matter?" rather than "what matters to you?"
- The need for training to enable them to support self care
- The need for clear information, access and ability to refer to sources of self care support

For Manchester's health and social care system:

- The need for a system wide commitment to a self care approach by all organisations

- Ensuring that training and support is available for staff – this needs to meet the needs of staff and service users and deliver consistent approaches

- That commissioning of self care support is co-ordinated, cost effective, evidence based and in sufficient volume. Financial pressures in the system can lead funding to be focused on those in the highest need; committing funding to self care requires a longer term, preventative approach

Although delivering this self care strategy will be difficult, there are existing examples of self care success stories in the city; it will be important to learn from them.

5 How will progress be measured?

The Health and Wellbeing Strategy outcomes framework includes the outputs, related outcomes and impact of implementing a citywide approach to enabling self care. These have been listed below.

Further work will is required to develop outcome measures that specifically capture the desired behaviour changes in keeping with the self care approach. A classification system has been developed for 93 techniques to change behaviour, grouped into 16 categories. By describing the techniques we are using in this way, we can begin to understand which techniques seem to be useful and which are not. The 93 techniques include those that are commonly used to change behaviour in health (e.g., goal setting) and those that are less commonly used (e.g., action planning). For each specific behaviour (public, patient or practitioner) we can describe the behaviour change technique(s) that are targeting the behaviour, describe the expected change and measure whether than change has occurred. In behaviour change theories there are many things that people think or feel that have been linked to changes in provider behaviours. We call these things "constructs". Measuring these constructs and changes in them after education and training (or other interventions to change provider behaviours) will give us information about how likely practice is to change. We will work together with academic colleagues, public health, service providers and service uses to develop appropriate measures.

Data collection in 2016/17 will be required to provide baseline measures of outputs that have not been recorded previously, in line with a new way of working. Tools that are both patient and practitioner friendly will need to be identified to record self care outcomes at an individual and population level

Self Care Outcomes Framework from Health and Wellbeing Strategy:

Outputs

- Increased number of frontline staff and volunteers across health, social care and VCS attending training and development activities.

- Increased number of local people attending courses about enabling self care and improving personal resilience

- Increase in amount of self help materials distributed or accessed via websites supporting self care e.g. "Choose Well" and "Help and Support Manchester"

- Establishment of local community asset building networks to promote and enable self care

- Increase in number of care plans recording information on patient and user involvement in care planning

Outcomes

- Increase in number of frontline staff and volunteers feeling more confident to support people to self care.
- Increase in number of people able to self care and manage their long term conditions
- Stronger infrastructure for community asset building around health
- Increase in people involved in their health and social care needs assessment and receiving a copy of their care plan
- Increase in carers who have been offered / received a carers needs assessment
- Reduced prevalence of lifestyle risk factors

Impact

- Increased independence, self-reliance and wellbeing of residents
- Reduced dependence on health and social care services
- Reduction in use of hospital services
- Reduction in absence from work as a result of long term conditions
- Increased knowledge of health conditions and their management
- Improved experience of people using services
- Improved clinical outcomes
- Reduction in impact of long term conditions on quality of life
- Reduced barriers to behaviour change
- More confident and effective workforce across health, social care and VCS
- Culture change towards self care and emotional resilience in local communities
- Patients and service users more involved in their own care

6 Appendices

Self Care Vision Story

\Self Care\Self Care Strategy\One Team S

What will we achieve in the short-term (2016-17)?

Enable people to access, understand and use the information they need, to care for and support their own health and wellbeing

- Increase in the number of people using current online support tools to manage their health and wellbeing
- Increased number of local people attending courses about enabling self care and improving personal resilience
- All One Team information sources reflect self care messages
- Self care app developed
- Explored innovative solutions to provide accessible, updated information in one depository (single point of access)
- All Wellbeing Service practitioners are aware of and promote publicly available information sources for enabling self care
- All One Team staff know how to sign post to self care information and resources

To enable people to identify lifestyle changes and goals for themselves, improving their physical and mental wellbeing and preventing ill-health

- All one team staff trained in enabling self care
- Increase in the number of staff changing the way they work with people
- All Wellbeing Service practitioners have skills required to support clients to make positive lifestyle changes and enabling self care
- Local community asset building networks are promoting and supporting self care

To facilitate collaborative decision making between people with physical and mental long term conditions and the teams that work with them

Appendix 2: Mid- term objectives

- Develop a shared understanding of a "person centred approach" and the competencies and skills required to achieve this
- Increase in the number of people who are satisfied with their experience of care and feel involved in making decisions about their care
- Increase in the number of carers who feel supported to care and improve their quality of life
- Increase in number of people with long-term conditions who have personalised collaborative care plans and clear goals
- Increase in number of care plans recording information on patient and user involvement in care planning

To facilitate the changes in the system required for enabling self care

- The knowledge, skills, behaviours and attitudes for One Team (health and social care practitioners) to deliver self care approach are well defined
- Training framework for self care approach embedded in workforce development plan agreed for One Team
- All service specifications and contracts for providers of health and social care as part of LLLB have the requirement for staff to have knowledge and skills in self care
- Systems in place to measure outcomes required to establish baseline indicators for monitoring progress
- One team community asset mapping and network building plan developed
- Links formed with regional partners (e.g. HENW) to develop understanding of health literacy to inform work locally

What will we achieve in the mid-term (2017-18)?

Enable people to access, understand and use the information they need, to care for and support their own health and wellbeing

- Increase in people's understanding of how to navigate health system and use services appropriately
- Increased in number of local people attending courses about enabling self care and improving personal resilience and self efficacy
- Identify and address gaps in peer support networks.
- Self care app users feel able and confident to use information given

To enable people to identify lifestyle changes and goals for themselves, improving their physical and mental wellbeing and preventing ill-health

- Increased number of frontline staff and volunteers across health, social care and VCS attending self care training and development activities
- Increase in number of frontline staff and volunteers feeling more confident to support self care
- Increase in the number of carers who have been offered and received a carers needs assessment

To facilitate collaborative decision making between people with physical and mental long term conditions and the teams that work with them

- Increase in the number of people who are satisfied with their experience of care and feel involved in making decisions about their care
- Increase in people feeling in control of daily lives
- Increase in carer reported quality of life
- Increase in One Team staff members satisfied with care provided

To facilitate the changes in the system required for enabling self care

- Self care training and development for One Team embedded and sustained
- Gaps in knowledge, skills and attitudes for self care approaches are understood and mapped

Appendix 2: Mid- term objectives

- Re-commissioning of any health and social care services includes self care outcomes

- Stronger infrastructure for community asset building around health

What will we achieve in the long-term (2018-20)?

Enable people to access, understand and use the information they need, to care for and support their own health and wellbeing

- All partners in care (clinical and non-clinical workforce and carers) are aware of how to direct people to information and support for self care
- Increase in people who know how to manage minor ailments and how and when to access appropriate support
- Increased independence, emotional resilience and wellbeing of residents
- All local health and social care information sources reflect self care principle
- Increase in ”activation” or engagement with self care

To enable people to identify lifestyle changes and goals for themselves, improving their physical and mental wellbeing and preventing ill-health

- Increase in use of online tools for self care and lifestyle changes and users reporting positive outcomes
- Increase in use of self care app and users reporting positive outcomes
- Increase in proportion of contacts with Wellbeing Service reporting sustained achievement of lifestyle change goals

To facilitate collaborative decision making between people with physical and mental long term conditions and the teams that work with them

- Increase in the number of people who are satisfied with their experience of care and feel involved in making decisions about their care
- Increase in people feeling in control of daily lives
- Increase in carer reported quality of life
- Increase in One Team staff members satisfied with care provided
- Reduction in readmissions to hospital
- Reduction in avoidable hospital admissions
- Reduction in impact of long term conditions on quality of life

To facilitate the changes in the system required for enabling self care

- Increase in confidence of workforce (health and social care and VCS) to work with self care approach

Appendix 3: Long term objectives

- Reduction in reported system barriers to delivering self care approach

7 Acknowledgements

Manchester Living Longer, Living Better Self Care Group	
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