Cornwall: moving toward self-management

Summary

A public health led approach to kick start culture change, working with local partners in GP surgeries, the voluntary sector and people with multiple conditions, to co-design a range of services that encourage self-management. For people with multiple conditions, recognising there is no 'one size fits all' for self-management, there is a choice of services ranging from condition-specific information, personalised care and support planning, social prescribing and psychological and emotional support.

Main points

- Engagement events held as part of the development of the local Sustainability and Transformation Partnership to improve health and care services highlighted the need to encourage greater self-management of long-term conditions
- The council's public health team took the lead – but a great stress was placed on co-production with the public and patients
- Surveys and research carried out and a new model developed
- Various initiatives have followed, including social prescribing and a new talking therapies service with a focus on long-term conditions

> "THANK YOU FOR ALL YOUR KIND SUPPORT AND UNDERSTANDING YOU HAVE INCREASED MY POSITIVITY BY 200 PER CENT"
>
> – PATRICIA, PERSON WITH ARTHRITIS

Context

Cornwall is a largely rural county made up of a dispersed population mainly living in hamlets, villages and medium-sized towns. Around 560,000 people live in the county although the population increases in the summer because of the tourism industry.

Cornwall has average levels of deprivation, however almost 13% of the population live in what are considered to be the most deprived areas in the country. It also has an ageing population – nearly a quarter of residents are over the age of 65, which is higher than the national average.

What is more, there are relatively high levels of ill health. On average men spend 17 years in poor health at the end of their lives and women 19. Around one in 12 have cardiovascular disease and a similar proportion diabetes.

What has been done?

It became clear during the engagement events held as part of a review of services in 2016 under the Sustainability and Transformation Partnership – an NHS England scheme to encourage local areas to develop new ways of working – that there was a need for more self-management of long-term conditions.

The council's public health team took the lead on this and working with partners the following happened from 2017:

- A regular self-management leadership group was created, involving patient representatives, the voluntary sector, commissioners and clinicians
- Four sub-groups were established covering heart disease, cancer, diabetes and Chronic Obstructive Pulmonary Disease (COPD) to gather further insight and ensure a co-production approach was adopted by including patient representatives
- Surveys of the public and voluntary sector groups were organised
- A review of evidence and a health needs assessment were carried out

The findings from these activities showed that there was not a "one-size-fits-all" approach to self-management and, instead, it was important to offer a range of options and formats. For example, despite numerous promising digital developments in self-management support, 80% of respondents said they were most comfortable with face-to-face support, followed by group sessions or over-the-phone help.

It was also clear that poor health was taking its toll emotionally. 80% of respondents said they had experienced low mood, anxiety or depression related to their condition, but only 40% said they had received support for it.

This led public health to co-design a self-management model that had five clear strands:

- Peer and social support
- Personalised care and planning
- Healthy lifestyles
- Condition-specific information
- Psychological and emotional support

The model made clear these strands should ideally be available across communities and delivered in different ways to meet people's preferences whether that be in a group, individually or digitally.

What has been achieved?

Over the last year public health has been working with other partners, particularly the voluntary and community sector, to introduce some new ways of working.

A social prescribing scheme has been launched with link workers placed in 30 of the 60 local GP surgeries. More than 3,500 people have been helped so far to access activities in the community that will help them self manage their conditions. This includes things such as walking groups, dance classes and social activities.

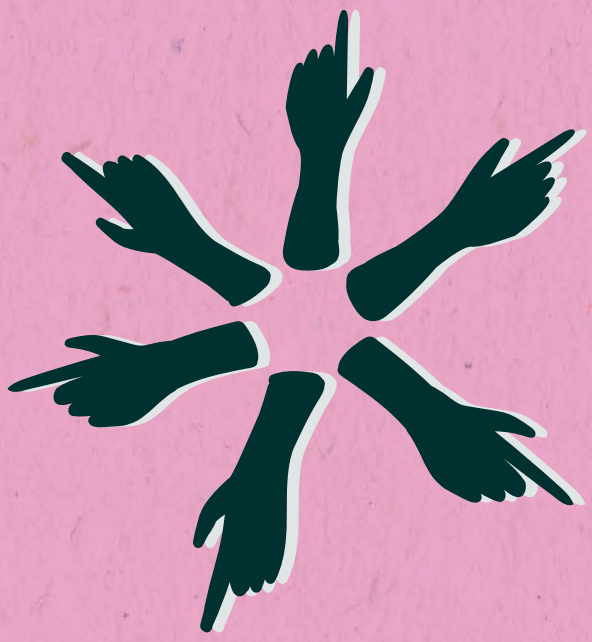
GP practices have also started working closely with some of the existing peer support groups delivered by Diabetes UK and local community groups, while the Healthy Cornwall Service, which runs the lifestyle advice and support programmes, has been more closely aligned with practices with some advisers spending time located alongside GP staff.

Meanwhile, the Eden Project has been asked to expand some of the work it has been doing in terms of walking and horticultural groups. In addition a new service to Improve Access to Psychological Therapy (IAPT) was launched via Outlook South West for people living with certain long-term conditions – chronic pain, diabetes, heart disease and COPD.

Those who have been helped report that it has transformed their lives and allowed them to take greater control of the health and wellbeing.

The experience of Margaret is typical. She is 63 and was referred to a link worker by her GP. She has asthma and limited mobility due to osteoarthritis. Her health had begun to get her down and she was feeling isolated and depressed.

She was given financial advice – she had debt problems – and was given help to get a new boiler installed. The link worker then got her involved with a local craft group and a choir. She has begun to make friends, go out more and is feeling much more motivated and able to keep on top of things. Patricia, who is 64 and has arthritis, has a similar story. She was helped to find voluntary work at a local clothes bank, which she says has made a huge difference. "Thank you for all your kind support and understanding you have increased my positivity by 200 per cent."



"SELF-MANAGEMENT IS NOT ONE SINGLE APPROACH. IT CANNOT BE PRESCRIBED OR PUT IN A PACKAGE LIKE A MEDICINE… IT TAKES TIME, BUT WE ARE GETTING THERE"

– RACHEL WIGGLESWORTH, CORNWALL COUNCIL

What lessons have been learned?

Cornwall has found that working with primary care networks – groups of GP practices – in local areas has been the most effective way of encouraging change rather than attempting to do things on a county-wide level.

Cornwall Council assistant director of public health Rachel Wigglesworth said: "The GPs work across 14 networks now across Cornwall and the Isles of Scilly – that has really helped to drive some of the changes on the ground.

"The local health and care system have started to value the contribution of the community and voluntary sector, from organisations like Diabetes UK and MacMillan to smaller Cornwall based community organisations. For example, we have tapped into local knowledge with the social prescribing work. There are seven charities that coordinate and employ the link workers. They are the ones that know what is going on locally and what is there to help patients. That insight has been invaluable – you cannot do that from the top."

What is happening now?

One of the next focuses in Cornwall is to develop the wider workforce. A lead coordinator within the public health team has been leading the roll out Making Every Contact Count training across a wide range of employers.

Over the last three years nearly 4,000 people have been trained via face-to-face or e-learning to improve confidence to have "healthy conversations" during everyday interactions with the public to support lifestyle behaviour change and promote self-management.

Meanwhile, clinical leaders are to undergo a health coaching training programme, which will build greater understanding of preventative approaches to help encourage culture change.

Ms Wigglesworth said: "Self-management is not one single approach. It cannot be prescribed or put in a package like a medicine".

"It is a culture shift, with professionals moving from 'what's the matter with you?' to 'what matters to you?', and with individuals becoming empowered and confident to manage their own health rather than rely solely on professionals. It takes time, but we are getting there."

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