STP aide-mémoire: Supporting people to manage their own health, wellbeing and care

Gateway no. 05301

1. Introduction

People who manage their own health, wellbeing and care both have a better experience of care and a reduced demand for high-intensity acute services. However, 40% of people have low levels of knowledge, skills and confidence to manage their health and wellbeing[1] and 44% say they would like to be more involved in making decisions about their care[2]. The health and care system can do much more to support people to make better informed choices and to be more active in managing their own health, wellbeing and care.

2. Success in 2020

i. **Care decisions are shared, helping to reduce unwarranted variation and supporting patients to make informed choices**

- Patients are routinely and systematically involved as active partners with clinicians in clarifying acceptable care, treatment or support options and choosing a preferred course of action.
- Patients and clinicians are supported by decision aids to help people think through the pros and cons of different care, treatment or support options.

ii. **Care planning and self-management is hardwired into how care is delivered**

- Meaningful care planning takes place for people with long-term conditions or ongoing care needs which guides the choices and actions of the patient and her/his professional team. This care plan is digital and can be shared between care settings and is owned by, and useful for, patients, their families or carers.
- People living with long-term health conditions or care needs are offered support to improve their confidence and their capacity to manage their own health and wellbeing, including:
  - Self- management education: formal education or training so people develop knowledge, skills and confidence to manage their own health and wellbeing
  - Peer support: people supporting each other to understand their condition(s) and to manage its impact
  - Health coaching: to help people set goals and take action, improving their health and lifestyle
  - Group based activities: activities that encourage healthier living and reduce social isolation (e.g. exercise classes or community choirs).

iii. **Social action beyond the NHS helps people improve their health and manage their wellbeing**

- The STP area works with their local authority to support the local population in building community capacity and resilience.
- Social prescribing is widely provided by primary care and whole population care models.
- Strong partnerships between the NHS and voluntary groups deliver health prevention and support for patients, carers and their families.
- STPs employ asset based approaches: community- based activities aiming to strengthen local skills, knowledge and resilience to improve health and wellbeing.

[1] Ellins J, Coulter A (2005) How engaged are people in their healthcare? Health Foundation
[2] CQC Inpatient survey (2014) Item 32

3. How are we going to get there?

Shared decision-making

- Identify possible target populations by using the NHS England 'where to look' packs and/ or through awareness of local concerns regarding waiting times. Cross reference this list of target populations with the decision aids that help the individual (and their doctor or healthcare professional) understand what the next steps are, considering the options, benefits and risks of each option and coming to a decision that takes account of the personal preferences of the individual.
- Focus on one population (e.g. people awaiting knee replacements) and make sure either a) all patients on a waiting list have made an informed decision to proceed with surgery and/ or b) all patients joining a waiting list make an informed decision to proceed with surgery.
- Train staff suitably to share decisions with patients and quality control their discussions by using the CollaboRATE measure .

Care planning and self-management

- Establish a baseline to understand current position in terms of health inequalities, local variation and patient preferences.
- Stratify your local population according to cost by either using linked data sets, such as the mental health and learning disabilities dataset, or by using one of the widely available risk stratification tools.
- Segment the highest cost users (50% of cost is typically incurred by 5% of the population) according to need and identify 3 to 5 segments to offer tailored support to (e.g. patients who are frail; patients at end of life; patients who are isolated and feeling lonely; patients with complex co-morbidities spanning physical health, mental health and social care; patients with dementia).
- Undertake structured conversations between people and practitioners to identify individuals' goals and the support needed to achieve them. Develop single plans that are outcomes-based ('what matters to me') and owned by individuals.
- Offer tailored support based on need, including anticipatory care planning, social prescribing, health coaching and/ or integrated personal commissioning or personal budget.
- Enable patients to better self-manage through improving information and health literacy. Useful tools include the self-care forum factsheets.
- Undertake ongoing reviews of individuals' support needs to ensure it reflects changing goals, needs and priorities.
- Invest in enablers including staff training to manage conditions and technology.
- Ensure systems and processes have been sufficiently tested, demonstrating functionality and benefit to the population before roll out.

Social action and community mobilisation

- Implement social prescribing to connect individuals to non-medical and community support services, for example, Westminster's social prescribing network.
- Develop a local menu of support options to allow easy access for people and simpler referral routes for professionals, for example Self Help UK, an organisation which helps create, support and promote self-help groups.
- Use evidence based IT to support the process of connecting people with their communities, such as social networks.