Blackpool Council

Lancashire County Council

NHS

Fylde Coast Self-Care Strategy 2017-2020

your care our priority

The Fylde Coast Vanguard

Contents

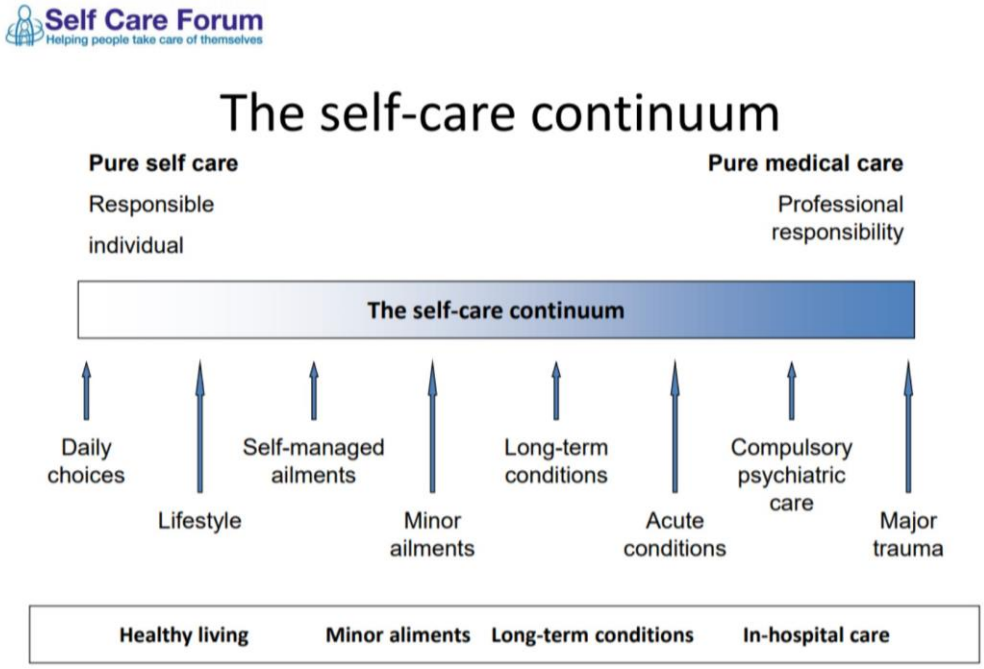
1. Introduction

The Fylde Coast New Models of Care Programme has aimed to transform the delivery of health and care in order to improve patient outcomes, provide better experiences for patients and staff and deliver sustainable change across the system. Prevention and self-care is at the heart of this ambition but will require us to look at innovative approaches to address the health inequalities that exist in our communities whilst responding to the prevalence increase in long-term conditions, including those with multi-morbidity.

People have a key role in protecting their own health, making healthy lifestyle choices and choosing appropriate treatment options in order to manage episodes of ill-health and managing long-term conditions. We need to empower the population to take action to stay healthy and look after themselves, their children, their families and others physical, mental, social and psychological health.

We know from evidence and good practice what is needed to help people to self-care across the continuum (see Figure 1) from self-responsibility to medical intervention in trauma situations. These range from the daily choices we make such as eating well, taking exercise and having the flu vaccine – to interventions aimed at individuals with long-term conditions; they make decisions about how to manage their conditions themselves every day.

Figure 1: The self-care continuum



A key component of self-care is about individuals taking responsibility for their own health and wellbeing. This strategy therefore seeks to create the conditions in order for people to feel empowered, willing and able, to self-care and for this to happen across all sections of the community in order to create large scale change.

This Self-Care Strategy will work to the Department of Health (2006)[1] definition of self-care:

> "*The actions that people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accident; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital."*

It recognises the three main component parts of self-care:

- for maintenance of good health and lifestyles and the prevention of ill health
- for episodic periods of ill-health and treatment of minor ailments
- of acute illness

We have already made good progress in working towards a vision of achieving greater levels of self-care across the Fylde Coast and this work has been fully embedded within the delivery of the new models of care neighbourhood teams with health coaching, assistive technology and health and wellbeing workers to help enable this to happen. We know, however, that there is much more that we need to do in order to change behaviours so that people and communities are using health and care services that are in high demand appropriately; so that people are getting the right care, at the right time, by the right person, so that services can better cope with demand.

Although we are seeing great system change within the local NHS in terms of new models of care and the establishment of community based neighbourhood teams, we need to bring patients and the wider community with us on this journey of change. This is very different to the way we have perhaps been traditionally working, where we naturally take over a person's care and treat what we see. We need professionals to think differently so that they look beyond the condition they are treating, and we need patients and the wider community to play their part. In order to do this, we need to change the power balance; put people in

control of their own care, and ensure that there is a two-way relationship whereby trained professionals understand their boundaries and people know what is expected of them.

We will need to treat people as individuals (patients, carers, staff and residents) and identify what their reason is to engage, what motivates them, and how to identify and problem solve any barriers to action, together.

This Self-Care Strategy aims to redress the balance, and put the systems and processes in place so that patients and the wider community feel able to self-care; that they have the confidence, knowledge, resources and support to make it happen, and that they know when to ask for help and when to contact services for support.

2. Aims and objectives

We want all sections of our community to have access to the information, advice, support, tools and resources that they may need to make healthy lifestyle choices, so that they may maintain and improve their physical and mental health and wellbeing, and feel able to manage their own (long-term) conditions; to prevent them escalating from something manageable into a crisis situation. In order to achieve this, we will:

- focus on healthy lifestyle choices, getting people to quit smoking, drink less alcohol, eat a healthy diet and take more exercise
- increase levels of social prescribing as an alternative to medication, and connect people to peer support and group activities to support health and wellbeing. All social prescribing activities need to be inclusive to all and well publicised
- value the role of people and communities in their health and wellbeing, focusing on their strengths and what they can do, not what they can't, through co-production, volunteering and social movements for health
- support and integrate the voluntary, community, faith and social enterprise sector, working alongside people, families, communities and the health and care system

The Fylde Coast Self-Care Strategy 2017-2020 therefore encourages the commitment to empowering people and communities to take greater responsibility for their own health, and is built on the guiding principles of:

- building on the assets/strengths (e.g. knowledge, skills and experiences) that already exist in the community
- people and communities, including the workforce, are equal partners in changing behaviours, building resilience and providing mutual support
- the community is at the heart of the New Models of Care transformation agenda and the decisions making, design and delivery of the Neighbourhood Teams

3. Why do we need prevention and self-care?

The Fylde Coast area covers the footprints of NHS Blackpool Clinical Commissioning Group (CCG) and NHS Fylde and Wyre CCG. This area had a total resident population of approximately 327,500 in 2016[2]and there were 321,803 patients registered with the GP practices in the two CCG areas[3]. 53.1% of the registered population of the area were registered with an NHS Blackpool CCG GP practice, whereas only 42.5% of the total resident population lived in Blackpool. The Fylde coast area had a much older population than England as a whole, with 22.9% of the resident population over the age of 65 years compared to 16.9% in England. Fylde and Wyre had a particularly elderly population with 25.5% aged over 65 compared to 19.3% in Blackpool[2].

Deprivation is closely correlated with poor health and wellbeing. The Index of Multiple Deprivation (IMD) is calculated to estimate the level of deprivation experienced in an area taking into account income, employment, health and disability, education, barriers to housing and services, the living environment and crime. The resident population of Blackpool experienced the highest level of deprivation of any local authority in England, while both Fylde and Wyre districts experienced levels of deprivation lower than the England average[4].

14% of adults across the area self-reported that they have some problem in washing or dressing themselves compared to 9% in England as a whole. 0.8% of adults reported being completely unable to wash or dress themselves in the area. 8% of adults self-reported having severe problems walking or were unable to walk at all compared with 5% in England. 20% of adults also reported caring for someone with long-term physical or mental ill health/disability or a problem related to old age compared to 18% nationally[5].

Levels of estimated and diagnosed disease prevalence[5] are higher across the area than in England as a whole, with levels in Blackpool higher than in Fylde and Wyre. Over 15,500 (4.9%) people have been diagnosed with Coronary Heart Disease (CHD) across the Fylde Coast, 32,200 (3.3%) with depression, 19,700 (7.4%) with diabetes and 10,500 (3.3%) with Chronic Obstructive Pulmonary Disease (COPD). In comparison, diagnosed disease prevalence across England is significantly lower; CHD, 3.2%; depression, 8.3%; diabetes, 6.5% and COPD, 1.9%. Estimated levels of disease are also much higher than national averages[6].

Lifestyle is strongly associated with levels of disease prevalence and the Fylde Coast shows higher levels of smoking, obesity and physical inactivity than across England.

It is estimated that approximately 19% of the population are smokers, 69% are overweight or obese and 35% are physically inactive. In comparison, 15.5% of the England population smoke, 65% are overweight or obese and 29% are physically inactive.

4. Drivers for change

Given the increasing burden of long-term conditions, taking a preventative approach to risk factors is essential. The three greatest risk factors for disease in the UK and locally are[7]:

- Smoking: the primary cause of preventable illness and premature death in the UK, leading to 100,000 deaths per annum. In England, smoking accounted for 5% of all hospital admissions among adults aged 35 years and older in 2010–2011, contributing to an overall cost to the NHS of £2.7 – £5.2 billion each year.

- Obesity: increases the risk of developing a number of long-term conditions, such as diabetes, cardiovascular disease and cancer. On average, obesity reduces life expectancy by 3–13 years and in 2007 it was estimated that the annual direct healthcare cost to the NHS in England for diseases due to obesity was £17.4 billion, with indirect costs of £15.8 billion. By 2050, it is predicted that this cost will rise to £49.9 billion.

- Alcohol: alcohol misuse led to 1.1 million hospital admissions in the UK in 2010–2011, resulting in 15,000 deaths and a £2.7 billion cost to the NHS. With people drinking 90% more than they did in 1960, they are setting up a time-bomb for future management.

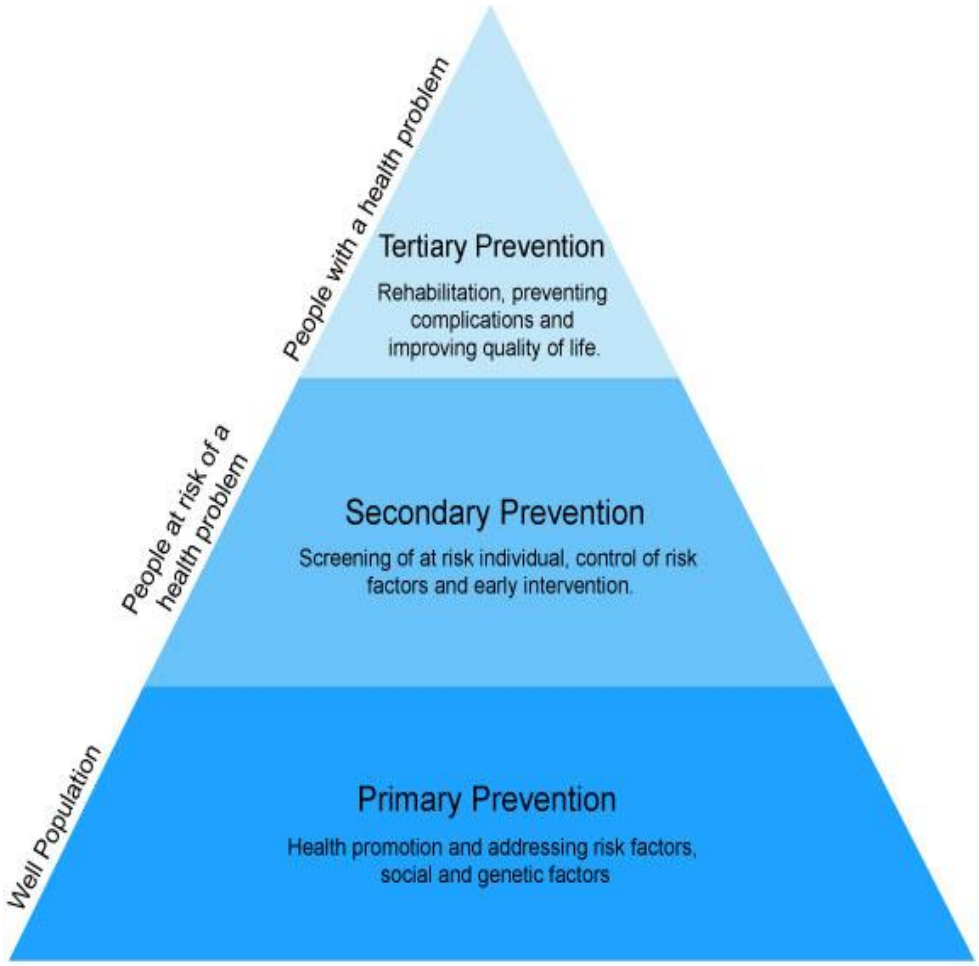
Prevention is often broken down into three general approaches (see Figure 2): primary, secondary and tertiary prevention[8], and can be explained as:

- primary prevention aims to protect healthy people from developing a disease in the first place, through such measures as good nutrition, regular exercise, avoiding tobacco and alcohol, and receiving regular medical check-ups. Primary prevention also extends to population-wide measures and social determinants of health, such as improving air and water quality, mass immunisation, and strengthening family and community ties to promote good mental health. The focus is on maintaining good health, independence and promoting wellbeing and interventions include providing access to good quality information, supporting safer neighbourhoods, promoting active lifestyles, healthy eating, smoking cessation, alcohol prevention and delivering practical services through social prescribing.

- secondary prevention aims to identify people at risk of disease and to halt or slow down any progression or promote an intervention to seek to improve their condition or situation. Interventions include population based screening programmes and individual case finding to identify individuals at risk of specific health condition or events e.g. stroke or falls or vascular risk through NHS Health Checks or those who have existing low level social care needs. Making Every Contact Count (MECC) through holding very brief holistic conversations at every opportunity and the development of support groups/buddies to provide peer to peer support for people with those with specific conditions are also useful interventions.

- tertiary prevention is aimed at minimising disability or deterioration from established health conditions or complex social care needs for patients who already have illnesses such as diabetes, heart disease, cancer or chronic musculoskeletal pain. Tertiary prevention consists of measures to slow down physical deterioration and is particularly relevant for patients with complex needs and focuses on their recovery, rehabilitation and re-enablement after acute exacerbation of their chronic illness i.e. self-management programmes.

Figure 2: Levels of prevention



Understanding these three levels of prevention is important in the context of self-care as it recognises that each of these approaches has a critical role to play in disease prevention. In order to maximise prevention opportunities and prevent people and communities from becoming ill in the first place, we will need to consider all self-care work in the context of this pyramid of needs and opportunities.

Actions and approaches will need to be multi-faceted and include; help from voluntary sector partners, investment in evidenced based approaches and the emergence of independent peer-to-peer communities.

5. Strategic context

The Health and Social Care Act 2012 placed a new duty on CCGs to enable patients and their carers to participate in planning, managing and making decisions about their care. NHS England has produced statutory guidance, *Transforming Participation in Health and Care*[9], to accompany this legislation. It outlines self-management, shared decision-making and personal care planning as the three key approaches likely to improve outcomes, provide value for money and improve quality of life. Furthermore, the NHS England Business Plan *Putting Patients First*[10] states that "*by 2015, 80% of CCGs will be commissioning to support patients' participation and decisions over their own care. This includes information and support for self-management, personalised care planning and shared decision making within normal service planning and commissioning*."

NHS England's '*Five Year Forward View*' (2014)[11] set out how our health services need to change and argued for a new relationship with patients and communities. Its central ambition is for the NHS to become better at helping people to manage their own health: staying healthy, making informed choices of treatment, managing conditions and avoiding complications. The policy document acknowledged that the current social care and health system is unsustainable, and will buckle under the weight of demand unless we re-engineer planning and service provision to promote healthy choices, protect health, prevent sickness and intervene early to minimise the need for costly hospital treatment.

It acknowledged that focusing on treatment alone is not the answer. We also need preventative strategies that mitigate or defer the need for costly interventions and at the same time deliver better outcomes for individuals.

All Local Authorities (LAs) have a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. This is often referred to as the overarching guiding principle because it puts wellbeing at the heart of care and support. It applies equally to adults with care and support needs and their carers.

Wellbeing within the Care Act 2014, is a broad concept which relates to the following areas in particular:

- personal dignity (including treatment of the individual with dignity)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

How this happens will depend on the individual's circumstances, including their needs, goals and wishes, and how these impact on their wellbeing. There is no set approach. For example, for some people the ability to engage in work or education will be a more important outcome than for others, and in these cases promoting their wellbeing effectively may mean taking particular consideration of this aspect. Similarly, for other people spiritual or religious beliefs will be of great significance and should be taken into particular account. This Self-Care Strategy should support a flexible approach which allows for a focus on which aspects of wellbeing matter most to the individual concerned.

Much work has already been undertaken to formulate policies and strategies for prevention for the Fylde Coast and beyond. Prevention is currently co-ordinated across a number of organisations and strategic partnerships including the Health & Wellbeing Board (HWB) and Sustainability and Transformation Partnership (STP). These partnerships bring together

bodies from the NHS, local government, and other statutory and voluntary sector partners to jointly plan how best to meet local health and care needs and to commission services accordingly. Whilst alcohol, tobacco and obesity feature strongly in the strategy, additional priorities include mental health, and children and young people; all of which provide a significant opportunity to improve the health of the population by applying self-care principles.

At the time of writing this Self-Care Strategy NHS England had outlined ambitions for STPs to evolve into 'Accountable Care Systems' (ACS'

s), and proposed that these ACSs might become accountable care organisations (ACOs) but only after 'several years'. Eight areas of England had been identified to lead their development – with the Fylde Coast one of these areas, due to the history of local collaboration and the willingness of partner organisations to find common cause.

ACS's will involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population. Providers will take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population; and work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years (The Kings Fund, 14th June 2017)[12].

The most ambitious plans for ACOs in England will extend well beyond health and social care services to encompass public health and other services and, in the context of this self-care strategy, it is important that we push to use all public resources to improve health care while also tackling the wider determinants of health; taking a population health systems approach which seek to integrate care, and to improve the broader health and wellbeing of the local population.

In line with the NHS '*Five Year Forward View*'[11] we recognise that our biggest opportunity to achieve system change is to place greater focus on prevention and early intervention work for self-care, whilst recognising the key role of the causes; the wider determinants of health.

6. Stakeholder and community views on self-care

In order for this strategy to be as meaningful and effective as we possible, we believe that the views and experiences of local people should inform its approach. Therefore, a significant period of communication and engagement was undertaken with local stakeholders and members of the public in 2016/2017 which resulted in:

- a total of 449 people engaged. Of these, 188 were as a result of face-to-face methods
- more than 300 people completed our self-care survey either online or in person at local primary care centres
- associated social media posts reached a potential audience of 200,918 people and three local media articles were generated in relation to this work

A stakeholder event was held in September 2016 to launch the development process of the strategy and begin the wider communication and engagement needed to inform it. In total, 87 people attended the event with the vast majority of these attending in a professional capacity; however, there was a small number of members of the public also present.

Attendees heard from key speakers, including representatives of other NHS Vanguard areas, who shared their experiences of developing and enabling self-care strategies. Attendees then took part in round table exercises to begin mapping local community assets and discuss how more local people can be encouraged to make use of these.

The resulting themes from this exercise was that the Fylde Coast possesses a wide range of assets which enable self-care for individuals and communities but that these are not always utilised as well as they could be. Delegates at the event identified a number of factors which prevent people from utilising a range of local assets, including:

- people's personal motivations
- time
- lack of awareness that the assets and opportunities exist to support self-care

These findings were supported by the additional engagement work that was undertaken across the Fylde Coast with patient focus groups, and as part of the on-line survey whereby

they identified healthy lifestyles and behaviours as the key component of self-care (such as healthy eating and exercise) and that a lack of motivation and a lack of awareness of local community groups and other services which people could access to support self-care were perhaps the main barriers.

The on-line survey gave us the opportunity to ask additional questions to ascertain where respondents had sought self-care advice in the last six months, and a common theme was from healthcare professionals with an individual's GP as the most popular source, followed by a practice nurse and then a hospital doctor or consultant. The NHS choices website, and other health related websites (apart from NHS choices), family and friends or work colleagues were also identified as current sources for self-care advice and support.

When respondents were asked to prioritise which options would help them and others to take a more active role in managing their general health and/or a specific long-term condition, the responses showed people felt that support and advice provided to them via a GP or other health professional would be the most important and beneficial.

7. What needs to happen

In order to fully realise the opportunities that prevention and self-care has for the Fylde Coast; in response to evidence and good practice, matched with stakeholder and residents' views; the place and value of people and communities at the heart of health and wellbeing and the need to increase people's opportunities and confidence to self-care are paramount.

This inclusive approach must increase people's ability to manage their own health and wellbeing by ensuring individuals have the knowledge, skills and confidence needed to make informed choices, to make healthy lifestyle decisions and to manage episodes of ill-health appropriately.

Evidence shows that when individuals have control of their own health, wellbeing and care and are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

In order to make this happen, people need to do things differently**:**

1. all need to encourage, teach and support self-management and self-care;
2. use extensively brief intervention opportunities (MECC) and health coaching methods to engage with people and share responsibility for health improvement and care;
3. use Patient Activation Measures (PAM), person centred care planning and shared decision-making tools in order to share power;
4. do more to identify, support and involve carers;
5. make better use of technology such as self-diagnostic and management tools, where appropriate to the needs and circumstances of the individual and community;
6. better share information: people don't know what they don't know;
7. making a major shift in how many people perceive themselves, from the current perception of being passive recipients of services to a new identity as active participants who make lifestyle choices which will not only benefit themselves, but potentially their community as well;
8. use positive role models and members of our community who act as informal wellbeing workers to encourage positive behaviour change.

In 2015 Public Health England and the Institute of Health Equity published a report entitled 'Improving health literacy to reduce health inequalities'[13.] This showed that up to 61% of the

working age population in England finds it difficult to understand health and wellbeing information. Low levels of health literacy impact significantly upon a person's ability to:

- manage long term conditions
- engage with preventative programmes and make informed healthy lifestyle choices
- keep to medication regimes

This leads to worse health outcomes across a range of indicators, increased health inequalities for affected individuals, and increased preventable mortality.

We need to act on this information and do more to positively engage with patients and the wider community in the things that we do; the things that are important to them and the things that will impact on them, from planning campaigns to shared decision making about services, care and support.

8. Priorities and actions to increase self-care

Focus on healthy lifestyle choices, getting people to quit smoking, drink less alcohol, eat a healthy diet and take more exercise

In order to ensure self-care is considered for the maintenance of good health and lifestyles and the prevention of ill health, this Strategy will recognise and maximise person and community centred approaches to self-care and take action to prevent the development of long-term conditions in the first place. We recognise that this then has the potential to improve outcomes not only for individuals, but also in the development of strong and resilient communities, so, over time, helping to reduce demand on formal health and social care services.

Interventions to support self-care can be targeted at individuals who do not have long-term conditions as well as those living with severe or multiple long-term conditions. This then recognises that individuals without any diagnosed conditions may still have risk factors for disease or be undiagnosed and therefore self-care primary prevention interventions are appropriate for these groups. This will include self-care interventions to reduce smoking, reduce harm from alcohol, encourage more physical activity and improve mental health.

Increase levels of social prescribing as an alternative to medication, and connect people more so that peer support is widely available to those who want it and group activities to support health and wellbeing are inclusive to all and well publicised

Social prescribing is a key enabler creating community resilience. Health inequalities can shape people's access to services, and health outcomes and New Models of Care are taking the opportunity to tackle these inequalities by ensuring all groups have equal access to health, care and prevention opportunities. This is about recognising diversity of need and experience, and understanding how these things shape access to for people and communities. Reaching out to and involving a wider range of people can help us to ensure that a range of interventions reflect the communities they serve.

Charlotte's story

When Charlotte was young, sport was not the most favourite of topics. Living in a damp house and both parents smoked, she states that every little cough or cold would develop into a bronchial infection and she couldn't run 800m.

When she left school and started work, Charlotte began smoking and continued for a number of years until she stopped in her mid-forties. A couple of years later, and largely down to lack of social networks, Charlotte joined a group of ladies through the Breeze cycling network.

Breeze rides were started by British Cycling, Sport England and Sky with funding from the National Lottery, with the aim of encouraging women to get fit and have fun on their bikes; led by women for women.
Charlotte started with slow pootles on a mountain bike up to Cleveleys and back from North Pier, stopping for cake, coffee and a chinwag half way... she felt like she'd done the Tour de France!

Fast forward three years and she is now on a triathlon training camp in Mallorca with the world champ for her age group (who lives locally), she has entered into a half Ironman event, is taking part in relay teams for two full distance events and a range of triathlons, as well as running and other events locally throughout the year!
Charlotte also volunteers on a Parkrun locally but it's not all running and cycling, they do other less energetic stuff too!

Obviously, many people don't do this level of sport, but Charlotte's advice is to stick with something a bit more manageable in terms of time and commitment, and just enjoy.

An integral part of the New Models of Care is the delivery of a Directory of Services (DoS) that will meet the service information needs of residents and professionals alike. The aim is for this information to be made available to people, residents and professionals in a simple, concise and appealing manner so that they are encouraged to use this as a first point of call when searching for information on how best to meet their needs.

The FYi Directory is the first of its kind in the country.

It brings together information on the wide range of local health and social care services, in addition to other council services, community clubs, social groups, wellbeing activities and events, into one comprehensive source.

Accessible online at www.fyidirectory.co.uk, the directory is open to both the public and professionals to utilise. Within the directory are a number of features which professionals can utilise to aid signposting. These include:

- postcode search; view services by proximity to a desired area or location
- a 'shopping basket' function; add multiple listings of your choice to a shortlist (just like a basket as you would if online shopping) which you can then print off
- text messaging; send information listings direct to a mobile phone within seconds and free of charge
- a map view; view services on an interactive map and view directions thanks to integration with Google Maps

Anybody without computer or internet access can still find out information about local services by calling the dedicated FYi Directory helpline on 0800 092 2332. A member of the team will be able to assist and if required, arrange for a copy of the necessary information to be sent by post too.

Evidence has shown group activities can contribute to increased feelings of wellbeing, reduce social isolation and that healthy activities can be influential in changing behaviours.

Value the role of people and communities in their health and wellbeing (focusing on their strengths and what they can do, not what they can't), including through co-production, volunteering and social movements for health

The Fylde Coast New Models of Care programme seeks to ensure that the Care Teams' understanding of an individual's ability to contribute to the management of their own health and wellbeing is central to designing patient-centred care plans and goals. This includes the development of a unique non-clinical role of a 'Health and Wellbeing Support Worker'. Use of the PAM tool will also help to identify the knowledge, skills, and confidence an individual has to manage their own health and wellbeing, and then for services to tailor their approach to supporting the individual.

The PAM itself is a driver and what follows are the tailored interventions that are appropriate for the individual. Evidence points to a 'health coaching' approach as being one of the most effective ways to improve activation. Therefore, a programme of 'Health coaching and activation skills' is being developed on the Fylde Coast to ensure health care professionals will have the skills to be able to have better conversations with patients.

The clinical lead for the extensive care service, said: "We're really pleased to be one of the first areas to benefit from this tool. It will help us to improve the experiences of our patients by making sure that the support we provide takes into account their own individual needs.

"*We know when patients feel confident and involved in the control of their healthcare that this leads to better outcomes*."

Volunteers are also an important part of delivery of this priority. They are crucial to health and social care delivery and beyond. We are working to extend volunteering opportunities; recognising the differences between formal and informal volunteering. Volunteers are members of the community who will help to connect people to groups and assets in their community with a key role in improving communication and engagement with people and communities, asking what is important to them, what they need and how we can work together to improve things.

We need respected members of the community who are already supporting others and linking them into resources of some kind. Some of these people are actively involved in community forums and we are looking to further strengthen these connections by working with additional people who may not have been involved in anything before. It is important for the local community to lead this as we will then know what best fits what the community believes it needs, opportunities and solutions are.

"Since starting on these creative courses, I have felt a lot more confident to the point that I have now started a volunteering role."

"By attending the course, I feel human for the first time in years."

"I now feel more like myself and just being around complete strangers is not as daunting. Somehow this has opened a whole new lease of life and I now believe in myself."

"Over a year ago I started suffering with depression, anxiety and low confidence. Wanting to better myself, I enrolled on a wellbeing course. I got a lot from the course and I now progress positively every day continuing to use the techniques I gained from the course."

Support and integrate the voluntary, community, faith and social enterprise sector; working alongside people

The voluntary, community, faith and social enterprise sectors provide a rich range of activities, including information, activities, support, advice and advocacy. They deliver vital services with paid and volunteer expert staff. The NHS Five Year Forward View[11] recognised that they are often better able to reach under-served groups, and are a source of advice for commissioners on particular needs. They are essential partners in empowering patients and communities in health and care, and will need to be central to the development of this Self-Care Strategy.

In order for individuals and communities to become more resilient it is important to support our voluntary sector, offering groups and resources within communities that are strong enough to support people to stay well.

An example of this is the Blackpool Fairness Commission; a forum whereby leaders of voluntary sector groups across the Fylde Coast meet with statutory and private sector partners to:

- enable sharing of information, experience, good practice, skills and resources provide opportunities to raise and discuss issues of common concern, gain mutual support and take collective action
- campaign and raise the profile of the community and voluntary sector's work
- facilitate cross sector partnership working

We will continue to build on this as a valuable resource in supporting collaboration and knowledge-sharing within the community. Actions have led this forum for us and in turn this helps raise the profile with statutory services of what the voluntary sector can do to support the health and wellbeing of people.

Blackpool Fairness Commission is a cross sector voluntary partnership made up of 18 members from across the public, private, voluntary, community and faith sectors. The Fairness Commission delivers a range of projects in Blackpool which help to develop social capital, reduce social isolation and loneliness, and create a more equal society for everyone.

Dr Arif Rajpura, Director of Public Health and Chair of Blackpool Fairness Commission said "The Fairness Commission is a phenomenal partnership, held together not by any legal framework but by the passion and enthusiasm of the participants who want Blackpool to be a fair and equal place for everyone. Over the last five years we have worked towards Fairtrade Town Status, we have a leading Dementia Action Alliance and we have been positioned on the world stage for our work on kindness. Blackpool Fairness Commission will soon open the doors on the community farm, a partnership project delivered in the heart of our Grange Park community; a project where working together partners have levered in nearly £500,000 of investment. I am immensely proud of the work of Blackpool Fairness Commission which demonstrates clearly that by working together aligning hearts and minds we can achieve wonderful outcomes."

Whilst recognising these areas of work and more that we have not said, this Self-Care Strategy must build on what we have and take it to the next level. We need to ensure we have a broad range of programmes and activities in place that demonstrate the breadth of activity that is responsive and relevant to the community. We want people to have the support that they need to access the information, advice, tools and resources needed to improve and maintain their health and wellbeing, manage their own conditions and prevent them escalating from something manageable into a crisis situation.

HEALTHIER FLEETWOOD
connecting our community

Healthier Fleetwood is connecting all parties in the community to share, promote and develop the many initiatives and groups in the Town which aid residents' health & wellbeing. As well as supporting existing projects we will set up our own, looking to make these sustainable by giving residents the confidence to take control of their lives'

Dr Mark Spencer of Mount View Practice played a key role in setting up the Healthier Fleetwood project. "Hope, a sense of purpose and control over your own life and your environment will bring major health benefits for individuals and the whole community. This is Health Creation. We talk about 'The 3 Cs'. Connecting to others, gaining self-confidence and being in control of your own life and your own decisions. There are already a number of NHS Services, local authority community projects, Fleetwood Town FC initiatives and self-help groups around that put some of this into practice. Walking Football is a great example. The first phase of Healthier Fleetwood is to connect people together using these existing things. We want to know what really matters to you, rather than 'what's the matter with you'. This isn't just about physical health but probably even more importantly about mental health and mental wellness.

It is imperative that this includes mental ill health as this has as much impact on service provision as physical ill health. National evidence indicates that treating people's physical and mental health problems in an integrated way can lead to better outcomes improving both people's mental health and the management of their long-term condition.

Going forward we will develop a model which integrates with service provision in order to reduce the likelihood of hospital admissions, reduce isolation and improve self-esteem so that we can prevent or delay the onset of ill-health; patients with existing long-term conditions feel better able to manage their conditions and all feel that they are a valued part of their community.

John's Story:

John had been visiting his local GP for irregular and high blood pressure which was putting his overall health at risk. John was asked by his GP whether he would like to be part of the Test Bed trial to see if he could manage his condition at home to avoid being prescribed medication.

John agreed to participate in the six-month trial, and within two weeks of this appointment, the appropriate equipment was delivered to John at home where he was given a demonstration and a user guide.

John started using the equipment at the end of January 2017 and submits his blood pressure, oxygen level and weight on a daily basis Monday – Friday. This information is sent to his GP who monitors it on a daily basis. If any results are of concern, John will receive a call from a healthcare professional who would advise him as to whether he needs to visit the practice, or what steps he can take to regulate his condition.

Since starting the trial, John has not had to visit his GP once. Clinical lead for the Better Care Together Vanguard Mark Denver explains, "By providing John with the equipment he needs to manage his health at home, and the re-assurance that we are monitoring his condition on a daily basis, means he doesn't have to attend the practice on a regular basis. This not only allows patients to lead a normal life, it frees up clinical time."

What John likes most

John explains, "I can take my own readings, and if high, I now know what I can do to reduce them. It allows me to manage and control my own health without needing to take medication or visit the doctor on a regular basis."

What would John change?

John's only wish is that he could continue using the equipment longer than the six-month trial. John has now invested in a blood pressure monitor of his own for home and adds, "Once the Test Bed trial is over, I plan to continue monitoring my readings on a daily basis and keep a record, so that I can make any changes needed to stay healthy."

9. Outcomes and evaluation

The benefits, and therefore the outcomes, of this Strategy are likely to be long-term, such as improved healthy life expectancy and more confident and connected communities.

The strategy aims to make best use of resources, so GP appointments and A&E attendance rates, urgent care and planned admission figures will also be of relevance, but with the restriction of confounding variables, and with an eye to the long-term.

Once the Self-Care Strategy is agreed, a detailed Action Plan will be developed to include evaluation and outcome indicators. What we already know, however, is that when people self-care, and are supported to do this, they are more likely to:

- experience better health and wellbeing
- 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

International evidence from some approaches to self-care also suggests that investment could reduce[1]:

- visits to GPs by up to 40%
- visits to outpatient clinics by up to 17%
- visits to A&E units by up to 50%
- prescription expenditure

10. Governance and accountability

In order to achieve the intentions set out in this Self-Care Strategy it is necessary to review and amend the governance structure overseeing this core element of the New Models of Care / ACS work across the Fylde Coast.

It is therefore proposed that a Prevention and Self-Care Board be established with membership drawn from partner organisations at a senior strategic level: health, local government (commissioner and provider organisations) and voluntary sector. This forum would act as the system leader for health, wellbeing, prevention and self-care and link to the prevention, patient activation and community centre approaches to health and wellbeing work being undertaken at a wider STP footprint.

This Board will report to the Fylde Coast Accountable Care System Executive Strategy Group which aims to:

1. further improve quality;
2. make best use of our resources; and
3. embed our very successful new models of care.

Partners include:

- NHS Blackpool CCG
- NHS Fylde and Wyre CCG
- Blackpool Teaching Hospitals NHS Foundation Trust
- Blackpool Council
- Lancashire County Council

References

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2. ONS, Population Estimates for UK, England and Wales, Scotland and Northern Ireland https://tinyurl.com/ybzvaomb
3. Public Health England, GP Practice profiles https://fingertips.phe.org.uk/profile/general-practice
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5. GP Patient Surveys and Reports https://gp-patient.co.uk/SurveysAndReports
6. NHS Digital, Quality and Outcomes Framework, 2015/16 http://digital.nhs.uk/catalogue/PUB22266
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8. Goldston, S. E. (Ed.). (1987). *Concepts of primary prevention: A framework for program development*. Sacramento, California Department of Mental Health
9. NHS England (2013) *Transforming Participation in Health and Care, Guidance for Commissioners* https://www.england.nhs.uk/2013/09/trans-part/
10. NHS England Business Plan (2013/2014) *Putting Patients First* https://tinyurl.com/y9fr2nde
11. NHS England, *Five Year Forward View* https://tinyurl.com/oxq92je
12. The Kings Fund, Accountable Care Organisations explained https://tinyurl.com/y8j62x3y
13. Public Health England, *Local action on health inequalities: improving health literacy* https://tinyurl.com/oxujlte

There following Self-Care Strategies were all considered when forming this strategy:

- Self-Care Strategy (2014) Bristol CCG
- Greater Manchester Self Care Strategy (2016)
- Gloucestershire's Prevention & Self Care Plan (2016)

Appendix 1

Self-care – A Review of the Evidence

Self-care in health refers to the activities individuals, families and communities undertake with the intention of enhancing health and wellbeing, preventing disease, limiting illness, and restoring health and wellbeing. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals. 'It is also described as the ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider.

Self-care is an integral part of daily life and is all about individuals taking responsibility for their own health and wellbeing, with support from the people involved in their care and in conjunction with care received from health and social care professionals. Self-care includes the actions people take every day in order to stay fit and maintain good physical and mental health, meet their social and psychological needs, prevent illness or accidents and care more effectively for minor ailments and long-term conditions.

Achieving outcomes in self-care and carer support requires a major shift in how many citizens perceive themselves, from the current perception of being passive recipients of services to new identity as active participants who make lifestyle choices which will not only benefit themselves, but potentially their community as well.

Prevention, self-care and enhanced carer support applies across the whole spectrum of need, from active, independent, mostly healthy citizens (universal public health) through to those individuals who require constant care and support such as people diagnosed with long-term health conditions (targeted prevention). Good quality self-care and carer support is equally important for people receiving long term care or people in hospital.

Establishing and improving existing mechanisms, services and developing innovative approaches to supporting healthy lifestyles for individuals who are well or have long-term conditions, and ensuring referrals into lifestyle support services is key to reducing and delaying demand for professionally led primary and secondary health and social care.

Self-care also aims to direct people to the right service at the right time. Furthermore, it aims to avert crises which result in increased demand for health and social care services.

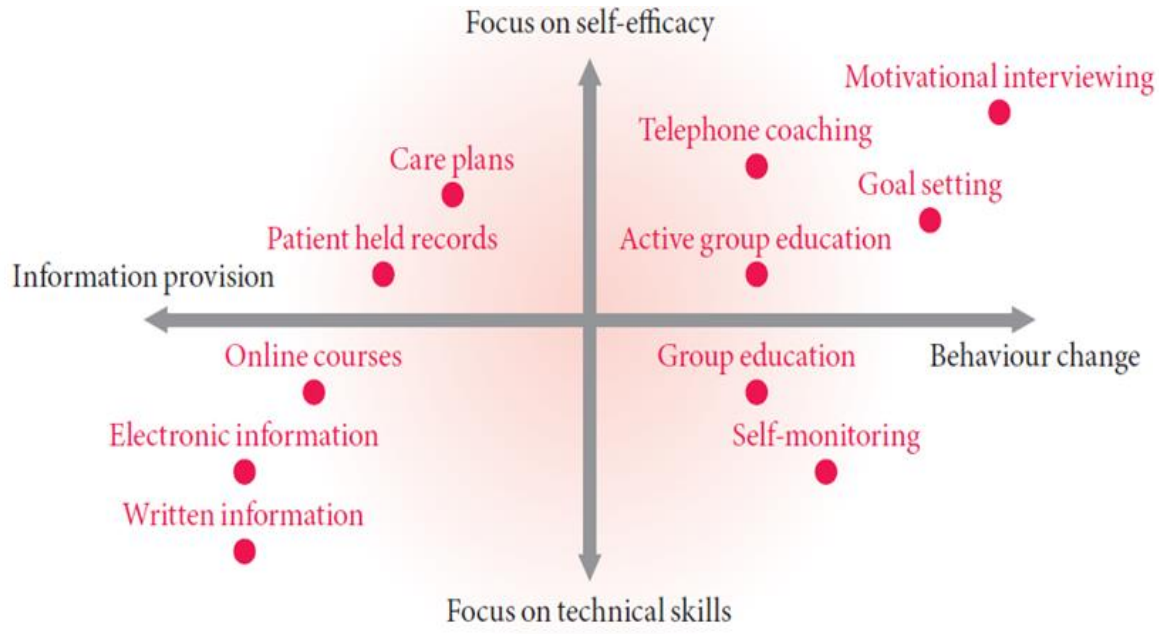
There is a large evidence base that provides support for the effectiveness of self-care, summarised below:

- Department of Health (2007) Research Evidence on the Effectiveness of Self-Care Support. London
  This document summarises the evidence from 160 systematic reviews on the effectiveness of self-care support for maintaining healthy lifestyle, managing minor ailments and managing long term chronic illnesses. The document highlights potential benefits of self-care support interventions for patients, the public and the care system itself.
- Department of Health (2000) The NHS Plan: A Plan for Investment, A Plan for Reform. London
  DH. Self-care is highlighted in The NHS Plan as one of the key building blocks for a patient-centred health service (DH, 2000) and identified as a key aspect of a model for supporting people with long-term conditions.
- Department of Health (2011) Healthy Lives, Healthy People: Our strategy for public health in England
  Describes an approach that will empower local leadership and encourage wide responsibility across society to improve everyone's health and wellbeing, and tackle the wider factors that influence it.
- The Marmot Review (2010) Fair Society, Healthy Lives:
  Sets out six actions to reduce inequalities, including enabling all to maximise capabilities and have control over their lives
- Department of Health (2015) 2010-2015 Government Policy: Carer's Health
  Identifies the need for carers to have access to high quality information and advice that's based on their personal circumstances.
- Department of Health (2014). Carers strategy: actions for 2014 to 2016
  Describes a strategic vision and outcomes for carers which include "Carers will be supported to stay mentally and physically well and treated with dignity."
- Long Term Health Conditions (2011) Research Study conducted for the Department of Health
  A research study commissioned by the Department of Health investigating attitudes

towards self-care using face-to face interviews with 1666 individuals. Findings suggest that a large number of individuals seek self-care advice and support.

For those living with long-term conditions, self-care includes eating well, exercising, taking medicine, keeping in good mental health, watching for changes, coping if symptoms worsen and knowing when to seek help from health professionals. Interventions can range across a continuum from passive information provision by providers (e.g. leaflets, electronic information) and providing technical skills (e.g. home measurement of blood pressure or blood glucose) at one end to interventions that aim to improve self-efficacy and support behaviour change.

Figure 3: Continuum of self-care and self-management interventions



In 2011, the Health Foundation reviewed more than 550 pieces of high quality research and concluded that “it is worthwhile to support self-management, in particular, through focusing on behaviour change and supporting self-efficacy”