NHS SCOTLAND

Health Delivery Directorate
Improvement & Support Team

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Keep Well

Long Term Conditions Collaborative

Making the Connections – Food For Thought:

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SCOTTISH GOVERNMENT

Long Term Conditions Collaborative

Making the Connections – Food For Thought:

Anticipatory Care, Self Management and Community-Led health improvement approaches for people with long term conditions

The Scottish Government, Edinburgh 2010

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Purpose

The purpose of this guidance note is to support practitioners to better understand the continuum of health improvement, anticipatory care and self management supports and the concept of community-led health. This is linked to a desire for further guidance on how to tailor supports and interventions to an individual's life circumstances, capability and readiness for self management and enablement.

The document highlights the synergy across the Long Term Conditions Collaborative, Keep Well anticipatory care programmes and wider health improvement networks as well as community, voluntary sector, health and local authority supports for health improvement and self management.

This resource will support practitioners to adopt an enabling and anticipatory approach – engaging and empowering people to take decisions and make choices which improve their health, wellbeing and health-related behaviours to reduce escalation of risk, need and dependency.

Context

Scotland has a poor record on smoking, alcohol misuse, diet and physical inactivity which are key risk factors for cardiovascular disease, chronic lung disease and diabetes. It also has an increasingly ageing population likely to live with a number of conditions for which they may require care and support. A long term condition is one that cannot be cured, lasts longer than a year and affects any aspect of a person's life. In Scotland, an estimated two million people live with one or more long term conditions. This represents significant challenges to meet the needs of people living with long term conditions and address the wider determinants of health such as lifestyle behaviours and socioeconomic deprivation.

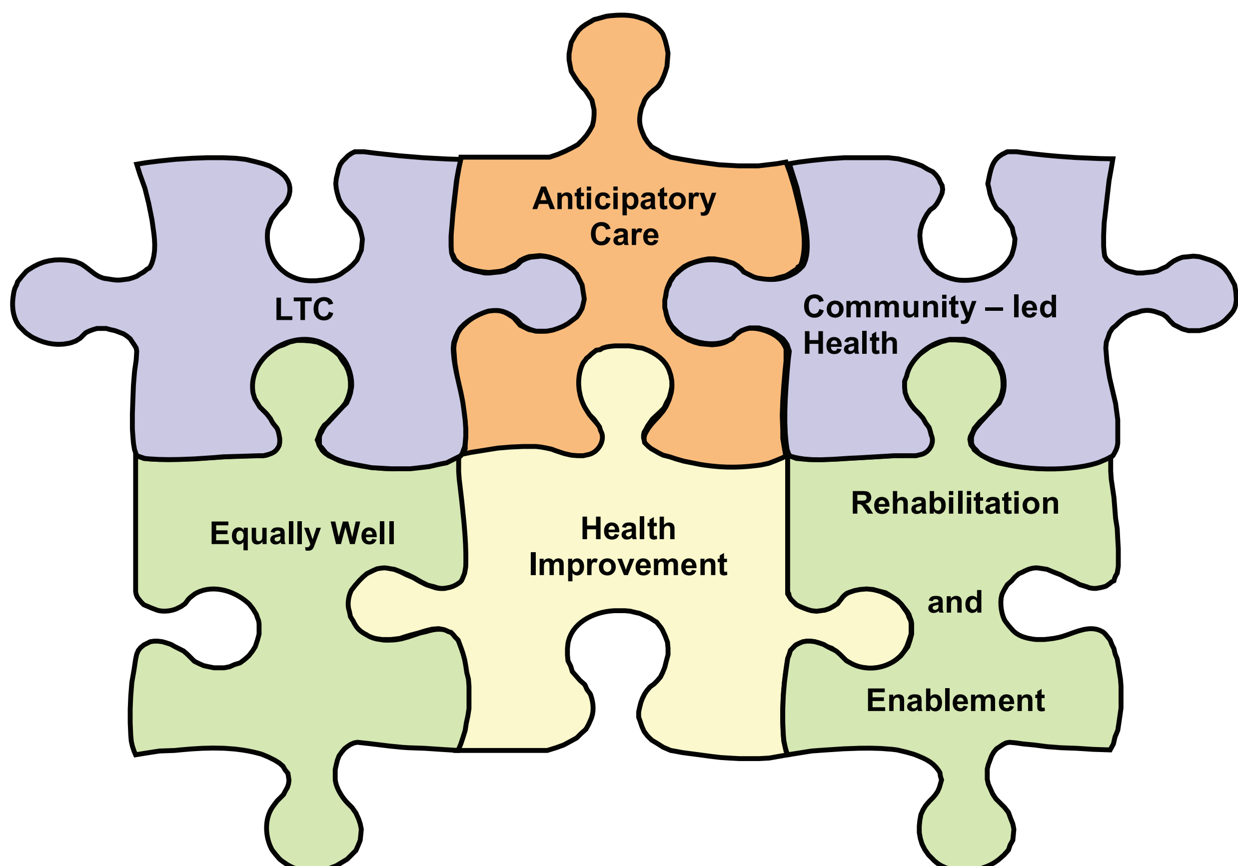
The nature of health care is changing; we are moving towards a system that focuses not just on physical health but also on health improvement and wellbeing, and which recognises people as co-creators of their health and health care. This approach is expressed in the vision for services which focus on strengths as well as treatment of symptoms and embrace concepts like hope, wellbeing, recovery, self determination and social inclusion.

People with long term conditions, and those at risk of developing long term conditions, are on a common pathway that views health as multi-dimensional, encompassing physical, psychological, social, emotional and financial wellbeing. This pathway needs interventions in all of these areas to support people to flourish and to live their lives to the full. Throughout this pathway approaches should be:

- Enabling and anticipatory or 'thinking ahead'
- Building community and voluntary sector capacity and develop health improvement services across all sectors
- Understanding the distribution of need in terms of inequalities and design services to address this
- Collaborative across all community planning partners to harness the synergy and to maximise benefits

Figure 1 illustrates some of the sectors and programmes which already contribute to this continuum of approaches.

Figure 1: Relevant Sectors and Programmes



Stronger links across programmes and shared learning across the full range of providers will further enhance the ability of practitioners to support people to improve their health and to manage their conditions.

The approaches used in these programmes share a number of common principles:

- Mutuality
- Person centred
- Holistic
- Anticipatory care
- Enablement
- Empowerment (of individuals and communities)
- Reducing health inequality

These principles are explored further in this guidance note.

Each section illustrates the contributions of specific interventions across the continuum of care for people having established long term conditions or risk factors for long term conditions.

The Chronic Care Model in Scotland

Wagner's Chronic Care model supports a bundle of evidence-based interventions and approaches to care that prevent, delay or reduce the impact of long term conditions. The model is based on the principle of empowering people to make informed choices about their care and support through a process of shared decision making with professionals.

This is in line with our commitment to a mutual NHSScotland that supports the individual to understand and to manage their condition so they can have greater choice and control and be the lead partner in their care.

Our model for long term conditions blends anticipatory care, targeted prevention and early intervention with proactive and integrated team based care, delivered through an enabling and person centred approach that aims to reduce escalation of need and dependency. It matches the level of service to the intensity and complexity of need, the capability for self management in the light of other available support and resources from family, friends, wider social networks and community and voluntary sector organisations.

Scotland's model for long term conditions is framed within an overarching commitment to the six dimensions of quality.

Figure 2: Scotland's Mutual Care Model for Long Term Conditions

Supporting Self Management

Better awareness of their long term condition helps people understand their symptoms and experiences and improves their long term health and wellbeing. The role of the care professional is to encourage self confidence and the capacity for self management, support people to have more control of their conditions and their lives and promote their efforts to enhance their health and wellbeing. This means having a shared approach to setting goals and problem solving, and signposting people to the type of support and information they need. It also means having a more outcome-focused approach to planning and reviewing their individual situation. It should take account, too, of people's inherent ability for self-healing and recovery and acknowledge that each of us is the expert in our own life circumstances.

Scotland's approach to self management is set out in the strategy document *Gaun Yersel!* This was developed by the Long Term Conditions Alliance Scotland (LTCAS) in partnership with people with long term conditions, and describes a set of principles that encapsulate the core messages of the strategy.

Figure 3: LTCAS Information

LTCAS is an independent, national charity that brings together hundreds of voluntary and community organisations across Scotland to give a national voice to ensure the interests and needs of people living with long term conditions are addressed. It does this through influencing and campaigning, supporting and improving practice, supporting the voluntary and community long term conditions sector and tackling health inequalities

The voluntary sector and people with long term conditions have extensive experience in supporting people to self manage and providing peer support and has a culture which maximises these approaches. Equal partnerships between health and voluntary sectors, which value each other's experience and contribution, can have a huge impact on outcomes for people and their carers. Further information on such partnerships is continued within *Guidance for Partnerships between the NHS and Community and Voluntary organisations for anticipatory care.*

The Long Term Conditions Alliance Scotland continues to play a lead role in implementing many of the recommendations in *Gaun Yersel!*

- operating a "long term conditions hub" that provides support for the work of the range of voluntary sector organisations that represent people with long term conditions
- gathering evidence of innovative practice and positive developments in self management
- supporting a shared approach to long term conditions policy development with the Scottish Government
- overseeing the Self Management Fund that builds the capacity of voluntary and community groups to support self management

Effective self management relies on the provision of accurate, relevant, timely and accessible information from a trusted source on a basis which people feel is sensitive to their situation. **NHS 24's National Health Information Support Service** is developing a single public portal for an online health information resource. It will offer quality-assured local and national information from the NHS and other sectors, including the third sector; a national health information helpline; and a network of branded health information support centres, embedded in local communities.

Food For Thought:

- Are all your practitioners aware of the "Gaun Yersel" national strategy for Self management? Have you developed a local action plan to take forward its suggestions?
- Are you aware of, and do you utilise, the voluntary sector for support and experience in your area?
- Has your team seen the document "Guidance for Partnerships between the NHS and Community and Voluntary organisations for anticipatory care." If so, have you considered ways to take it forward?

HEALTH INEQUALITY

Health inequality remains one of our biggest challenges in Scotland. **The Scottish Index of Multiple Deprivation** (SIMD) identifies small area concentrations of multiple deprivation across Scotland. These areas, datazones, are ranked in order of most deprived (Datazone area 1) to least deprived (Datazone area 6505). The result is a comprehensive picture of relative area deprivation across Scotland.

Equally Well: Report of the Ministerial Taskforce on Health Inequalities states that the healthy life expectancy in the most deprived 15% of datazones in Scotland is 57 years for men and 59 years for women. Poorer mental health is also associated with increased deprivation and health inequality. A combination of economic, personal, social and environmental factors influence health and contribute to the fact that people living in the more deprived communities are likely to have the most complex health and social needs. They are also more likely to be high users of health and social care services at a younger age.

The **Keep Well** programme targets 45-64 year olds in datazone areas which fall into the 15% most deprived in the country. Through systematic targeted approaches to case finding, people who have long term conditions not yet identified on GP disease registers, or other related systems, can be identified and more effectively managed. This may include secondary prevention, pharmaceutical care, lifestyle advice and signposting to local supports for self management. At the same time those who do not yet have a long term condition but are at risk of developing one can benefit from primary prevention activity, lifestyle advice and supports for health behaviour change.

Health Coaching

Health Coaching is a way of engaging with people from communities which have identified health inequalities. Coaches discuss health behaviours, health improvement, assist people to decide whether they are ready to change or not, engage people in setting appropriate goals, support self management and promote active participation in planning and implementing behaviour change. This approach is complemented by a variety of services to tackle life circumstances and the wider determinants of health. These include money and employability advice; bereavement counselling and welfare rights/benefits advice. Community-led health initiatives are organised and led by local people who provide a range of services and social supports (e.g. stress management and volunteering), often in areas with identified health inequalities. See pages 16-27 for more information on these services.

Risk Prediction

The Scottish Patients At Risk of Readmission and Admission (SPARRA) tool identifies people who have entered a cycle of repeat admissions to hospital in the previous three years and predicts the probability of future hospitalisation. For detailed information on SPARRA, please see the LTCC guidance note ***'SPARRA Made Easy'***. SPARRA is only one way of identifying people who may need proactive anticipatory approaches. Practice registers hold disease specific and prescribing information and can be used to identify people for targeted efforts to optimise primary and secondary prevention. This could be enhanced further by using markers of health inequality to identify people for targeted interventions.

Food For Thought:

- How do you address health inequalities in your day to day practice?
- How do you quantify and show the outcome from this work?

REACH AND ENGAGEMENT

Research commissioned by NHS Health Scotland explored motivators and barriers to engagement with the Keep Well programme. The report ***Strategies for Reaching the Target Population*** describes five broad approaches that can be tailored to specific target populations to enhance reach and engagement.

Practice-based approaches:	Mostly centred around letters and telephone calls. However, opportunistic contacts are key. Such as: • Reception staff identify eligible patients when they arrive at the practice and offer linkages to other supports/services. • Reception staff offer patients calling to arrange specific types of appointment (ie smear or BP check) an extended appointment to access further support at the same time. • Introduce flags/prompts on patient records to facilitate *ad hoc* engagement. • Each eligible patient is provided with an appropriate information leaflet by a health care professional when they visit the practice.
Local authority/private sector partnership approaches:	Located within the local authority or private sector, and working in partnership with the NHS. For example NHS Lanarkshire partnered with a private provider (ReferToUs), and NorthLine (North Lanarkshire Council call centre).
Community-based approaches:	Reach and engagement may be facilitated by an external community-based organisation. This may also be pivotal in the provision of services following onward referral, e.g. health coaching provided by the **Dundee Healthy Living Initiative**.
Outreach approaches:	Reach and engagement are facilitated through outreach workers, usually employed by the NHS. Outreach workers may support a person through their care pathway to help support adherence. Flexibility is important. Home visits, out of hours availability and high visibility in the local community have proven effective in engaging patients. For example, in Edinburgh outreach workers work alongside nurse case managers.
Wider NHS approaches:	Reach and engagement are facilitated by other groups within the wider NHS community, e.g. NHS 24 in Edinburgh; community pharmacists.

NHS Health Scotland maintains a practitioner intervention resource and a record of reported activity which provide assistance on methods of engagement and involvement.

SEGMENTING THE POPULATION

There are a number of ways to identify and stratify populations according to the level of complexity, dependency or risk. However it does not follow that those at highest risk, people with the most complex needs or those with the most to gain from interventions will be the people who are most willing or ready to engage with services. We must recognise this to ensure we engage the people who most need to be reached. To reach and engage with people, we must ask what is it that really matters to them in terms of their health and its place in the context of their personal, family, work, financial, social and leisure priorities.

Although a target population may have in common factors such as having a long term condition or risk factors for that condition, there will generally be large differences across the cohort regarding attitudes towards health and perceived value of the preventative or support services on offer.

The Keep Well target population is an example of a heterogeneous group, even when drawn from the most socially deprived areas and all within socioeconomic groups D & E. Research suggests the Keep Well target population can be segmented broadly into three groups based on their attitudes towards health and the perceived value of services on offer. These three groups can be described as ***health involved, healthy enough*** and ***health wary*** and are characterised as:

Health Involved
Convinced of effort required to stay/be healthy, see service as a means of maintaining good health, see few barriers of any kind to involvement, often have a 'reason' to be healthy. Will be early adopters of services. Barriers to involvement, whilst minimal, are most likely to be practical in nature, e.g. appointment times or economic constraints – unable to afford bus fares, child care costs or leisure facility entrance fees.
Healthy Enough
A direct link between maintaining good health and an improved life is not clear to the person – other life issues have priority, feel sufficiently healthy so that no extra effort is urgently required, expect they will get a warning of health risk and act then. Barriers to involvement could be practical, however, tackling rational and emotional barriers, e.g. other priorities or feelings of embarrassment, are most likely to lead to greater involvement.
Health Wary
Often have a significant emotional barrier to engaging with the service. This might be a fear of finding something they will be unable to deal with. Through previous experiences may feel unconvinced about what a service can do for them. There may be an aversion to visiting a GP/health professional for a variety of reasons, e.g. embarrassment, scepticism. Are most likely to have significant emotional barriers but there could be other factors needing addressed. Whilst all groups welcomed a respectful, non-judgmental tone engendering trust, this was felt to be especially important in this segment.

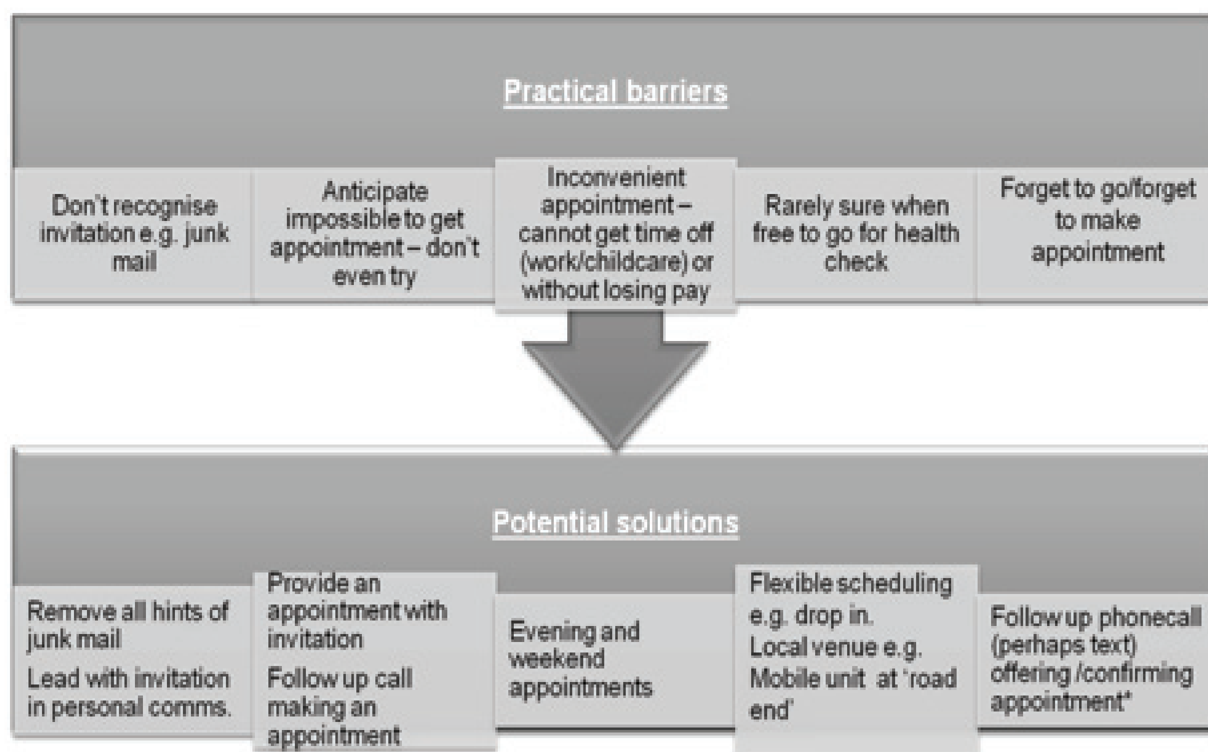
No single strategic approach will engage all segments equally. For successful engagement, the approach needs to be tailored to a number of factors:

- Recognising the wider social context for the individual
- Understanding emotional/rational readiness of the individual to engage with the service
- Overcoming practical barriers to reach

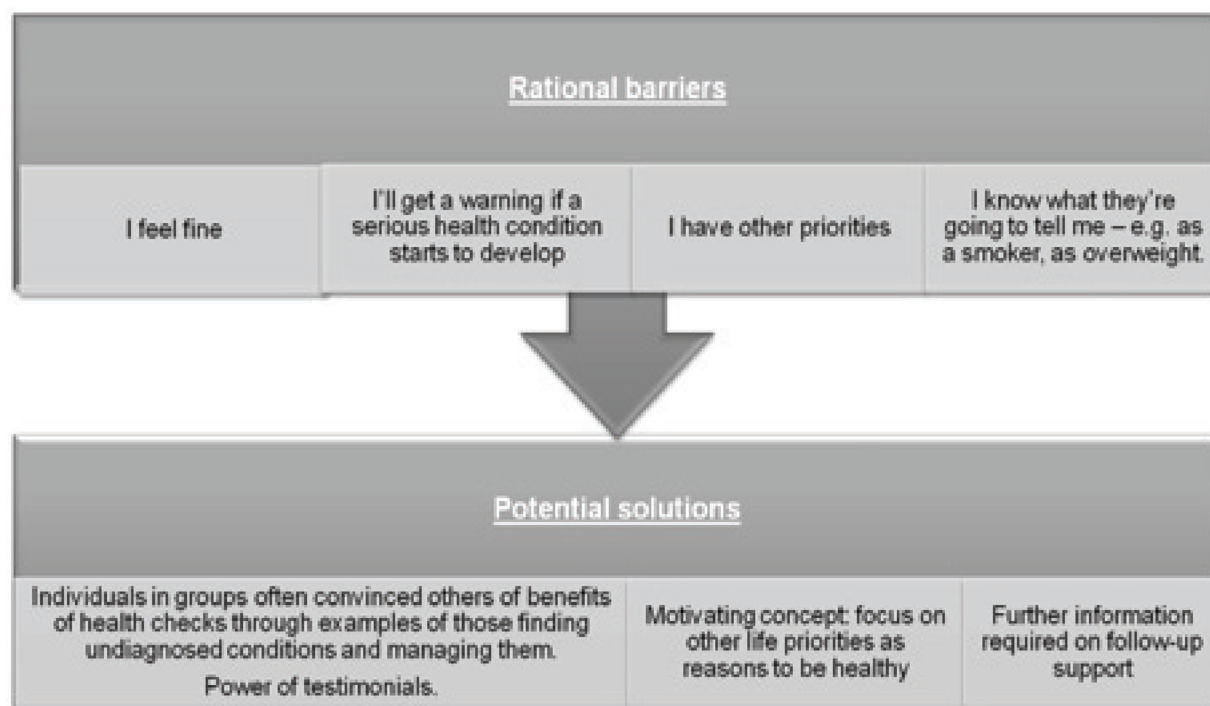
Barriers and Potential Solutions

The following models outline solutions to address some of the practical, emotional and rational barriers found within the Keep Well population. These reinforce the important role that motivational interviewing, and related activities, have within training and development of staff supporting anticipatory care and self management.

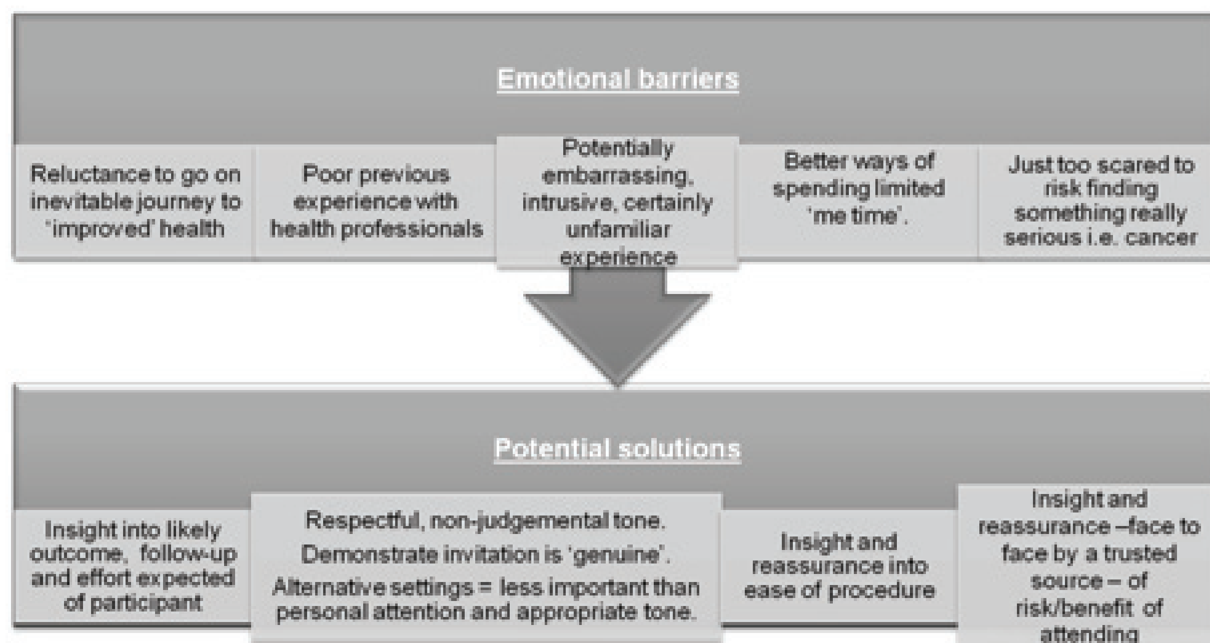
Practical Barriers



Rational Barriers



Emotional Barriers



Food For Thought:

- How can these approaches be used or adapted to help you identify and engage people with long term conditions about self management information, advice, support and education?
- How can this learning help you to design the supports people need to manage their condition?

HEALTH LITERACY

1 in 5 people in Scotland experience difficulties with reading, writing and numbers. These difficulties impact on people's health and on their ability to access and act upon health information *(New Light on Adult Literacy in Scotland (Scottish Government 2008))*

Tips for Practice

Don't assume that everyone is confident about reading, writing and using numbers.

Be prepared to explain things in a different way, using real-life examples.

Avoid jargon – it confuses everyone at times. Don't assume that everyone understands words such as "coronary" or "diagnosis".

Don't assume that everyone has the same grasp of English as you do.

Use clear language - and don't be afraid to check the person has understood.

"Would you like me to go over it again?"

If you realise someone might need your support, be sensitive and discreet – but don't be afraid to ask a direct question: *"Would you like some help with the forms?"*

Avoid information overload by giving information in small chunks.

Use information that is easy to understand.

Good quality information uses:	Poor quality information has:
• easy to read font and type size • simple, non-clinical language • appropriate headings and sub-headings to guide readers • personal experiences or examples that readers can relate to • visual images that reinforce text • information on how to get further help	• dense text • no visuals • fussy design • misleading or unclear headings • too much information • information not presented in a logical order • no explanation of technical terms or uncommon words

Visit **Adult Literacies Online** to see a guide on how to make your writing easier to read.

Here are some things you can say and do to help

Let me show you	Demonstrate what you want the person to do and get them to demonstrate that back. Use simple diagrams or models that explain conditions or treatments. Talk them through and give them the material to take home.
Tell me what you have been told so far	Ask people to tell you what they understand about their condition or treatment. This helps you to know how much they have been told already, how much they have taken in and how much more you need to explain.
Talk me through what you will do at home	This is the "teach back" method. Let people feel that you are just checking that you have explained things clearly. If there is any confusion or misunderstanding you have the chance to clarify instructions, perhaps rephrase them, offer checklists or diagrams and to reinforce the most important points.
Would you like someone to go over that with you?	Sometimes people need to repeat or practise things before they feel confident. Who else could support them to do this? Health outcomes are more positive if people leave with accurate information, confident that they know what to do and why they are doing it. Sometimes people will have difficulties understanding information because English is not their first language. In this situation you can ask them if they need the help of an interpreter or if they would like material in translation. Other people may have additional barriers to understanding you or expressing themselves due to a sensory impairment or a disability (including a learning disability or many conditions such as stroke, dementia, dyslexia and so forth). In this situation, you can ask them what additional support would help them communicate more effectively.

Lots of people have similar problems with reading and writing. There are people who can help you	If you think that someone would benefit from adult learning and it would be appropriate to do something about that now, talk about local learning opportunities. Encouragement from someone they trust can be just the motivator people need to get started. Ask if they have seen any of the Big Plus advertisements on television. If they have, you can help them to relate to the people and situations depicted. The **Big Plus helpline** will put you in touch with your local contact for literacies provision.
There are people who can give you the information and support you need	Signpost people to the relevant voluntary organisations who provide accessible information and can spend time helping people to understand the information so they are supported to manage their condition and make lifestyle and behaviour choices.
Ask me 3?	This approach, adopted by the US National Patient Safety Foundation, encourages patients to ensure that they have the answers to these three questions at the end of every health consultation. It is good health literacy practice to check that people have the answers to the three questions and have understood these. **What's my main problem?** **What do I need to do?** **Why is it important for me to do this?**

Many of our patients face difficulties in communicating with healthcare staff as a consequence of language and other communication barriers. NHS Health Scotland is working with NHS Boards to implement in partnership, a translation, interpreting and communication support (TICS) strategy. This will improve quality and service delivery for interpreting in community languages including BSL (British Sign Language). This covers face to face, telephone and online (for BSL). Communications work is also underway with many other partners to create an improvement plan for communication to support people with other communication difficulties (which may arise for example from brain injuries or learning disabilities). As service improvements are made, Health Scotland will be working on training and communications to build staff awareness and skills in caring for people with language and communication support needs.

Food For Thought:

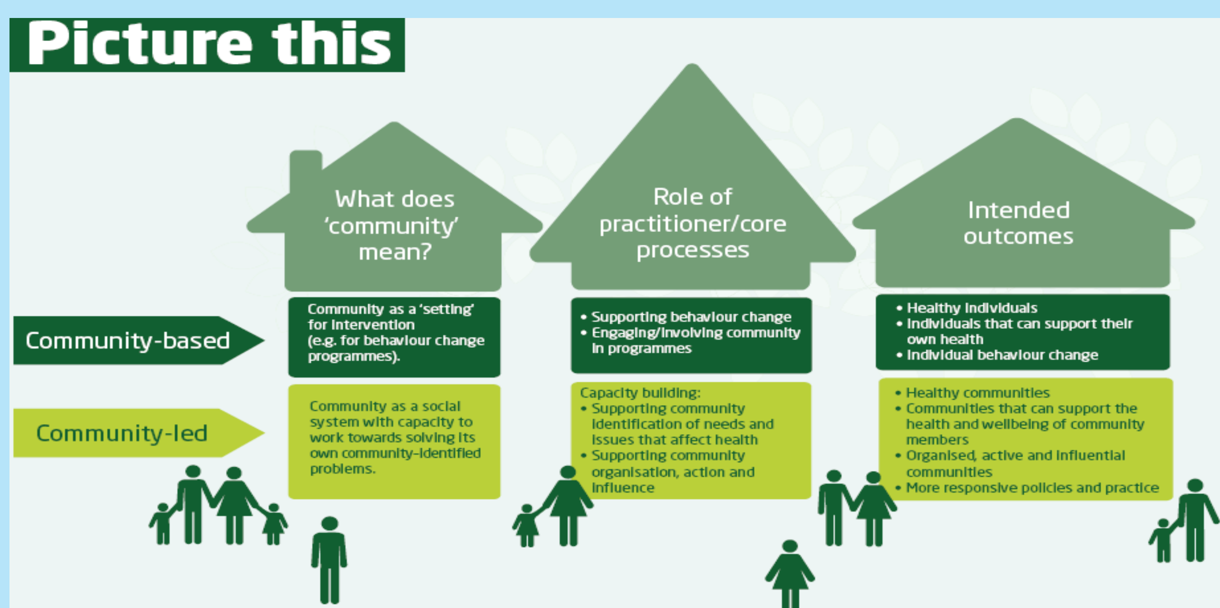
- Do you know your local contact for health literacy, advice and training?
- Do you signpost people to the relevant voluntary organisations who can provide support in this area?
- Do you know how to access the TICS resource?

COMMUNITY-LED HEALTH

What is Community-Led Health?

Community-led health, a community development approach to health improvement, is not the same as community-based health improvement. It creates a process for community members to develop skills, confidence and expertise to work collectively with others on a prioritised health issue which will bring about positive change. "Approaches that help communities to work as equal partners, or delegate some power to them, or provide them with total control, may lead to more positive outcomes". *(Nice Public Health Guidance 9)*

Community Health Diagram



Community-led health has been supported by the Scottish Government in 2008-2010 through the '**Healthy Communities: Meeting the Shared Challenge**' programme which brought together, at local levels across Scotland, staff from NHS, Local Authorities and Community and Voluntary Sector organisations and local people. The approach is framed within a social model of health, recognising that health is multi-dimensional and complex. The programme has provided a targeted and inclusive approach – engaging with the most disadvantaged and focused on tackling inequalities. The programme aimed to provide people with guidance and support throughout their life journey and opportunities to stay as active and involved as possible.

Why is Community-Led Health Important?

Direct personal involvement in community affairs provides meaning, purpose and connection to people's lives. A supportive community environment is extremely important to people's ability to cope and be positive. Positive outcomes are achieved through people being more involved, better supported, and more knowledgeable about how to manage their condition.

Community-led health initiatives contribute to improved quality of life outcomes across physical, mental and social wellbeing.

- Physical health improvements
  - General fitness
  - Strength
  - Mobility
  - Endurance
  - Ability to do daily tasks
- Mental health improvements
  - Ability to cope and be positive
  - Sense of confidence
  - Sense of being in control
  - Having self-esteem
  - Feeling secure and calm
- Social health improvements
  - Connection to stronger networks of support in the family or community.
  - Increased social activities
  - Social support
  - Wider contact with informal networks or organisations.

How can you join or create a Community-Led health group?

For staff the first step is to identify and signpost people to the appropriate local community group or organisation which might offer support or social connection. Information can generally be sourced from:

- The local Council for Voluntary Organisations (CVS)
- Local Authority Community Learning and Development or Social Work teams
- Community centres

Throughout Scotland there are many local community health initiatives, organised and led by local people providing a range of services and social supports, e.g. stress management services and volunteering opportunities. These organisations are often particularly active in areas where poverty and deprivation are most prevalent. There are National organisations which can provide information about community and voluntary sector health organisations across Scotland, including **Community Health Exchange (CHEX)**, **LTCAS** and **Voluntary Health Scotland**.

If there is an appropriate local community health initiative, they may be willing to work in partnership with you to generate a new support group. If no appropriate local group exists, you can bring together a group of people with common experiences of long term conditions to establish one. Invite someone skilled in community development to support the group to identify their priority issues and what might help. This might be provision of new information or of existing information and advice in more accessible forms. The very existence of a group will offer opportunities for peer support and extra social contact with those experiencing similar life challenges. If there is an appropriate local community health initiative, they may be willing to work in partnership with you to generate a new support group.

Food For Thought:

- Do you have contact with local community groups?
- Do you know how they could support people you see?
- If there is not an appropriate group for those you see with a long term condition, do you know who could support the generation of such a group?

HARDER TO ENGAGE – OR POORLY SERVED?

Certain individuals, groups and communities may have additional challenges that require a specially tailored approach to targeted health improvement and support for self management. For further information and links to the groups below, see page 31.

Food For Thought:

How well does your team or partnership support health improvement and self management for people from these community groups?

- Black and ethnic minority groups
- Travellers and gypsies
- Migrant workers
- Asylum seekers
- Offenders/ex-offenders
- Homeless people
- People with pan-disability
- People with learning disabilities
- Children and young people
- People with mental health issues
- People with learning disabilities

SUPPORTING PEOPLE TO RETURN TO OR REMAIN IN WORK

Evidence demonstrates that whether or not a person works, the kind of work they do and their working conditions are all important factors that influence health. This is particularly true for those people who are working and living with a long term condition.

A range of NHS services and activities are being established, developed and co-ordinated to support people to improve their health, prevent or reduce sickness absence and to return to work quickly following a period of sickness absence. These services include:

- Healthy Working Lives
- Fit For Work Services
- Condition Management Programmes
- Vocational Rehabilitation

Other services and support can be accessed through **Jobcentre Plus**, **Careers Scotland**, employability initiatives, trades unions and training and education establishments.

Healthy Working Lives

The Scottish Centre for Healthy Working Lives was established in 2005 as a result of the 2004 Scottish Government paper, ***'Healthy Working Lives: a plan for action'***. The programme aims to sustain and improve the health and well-being of the population of Scotland by delivering and developing services, either directly or through delivery partners, that promote the Healthy Working Lives agenda.

Fit For Work Services

Fit For Work Services (for people employed in small and medium sized enterprises) aim to maximise the functional capacity of the client so that they can return to the workplace at the earliest opportunity. They seek to provide early access to rehabilitative services for people with mild to moderate health conditions to minimise days lost from the workplace. The service adopts a bio-psychosocial model to identify contributing factors to the client's presenting problem and provide support and solutions. The client will have a dedicated case manager as a key element of the service to provide continuity from point of assessment to delivery of co-ordinated rehabilitation

Condition Management

The Condition Management Programme (CMP) is a voluntary, individually tailored programme provided by the NHS and Jobcentre Plus through the Pathways to Work package. The programme is confidential and available to anyone claiming health related benefits due to a health condition. It is delivered by registered health care practitioners.

The CMP model is underpinned by the principles of Cognitive Behavioural Therapy. Practitioners work with clients to:

- Promote a better understanding of their health condition and how to manage it, particularly in a work situation
- Build self confidence and belief in their ability to work
- Develop helpful thinking and behaviours which support improvement in quality of life

Vocational Rehabilitation

The need for a vocational rehabilitation model

Social engagement and purposeful occupation are central to nurturing a sense of self worth and well-being, and have been particularly prominent in rehabilitation offered within mental health services. Dedicated vocational rehabilitation is a crucial element to improve the health and well-being of working age adults, assist those with disabilities into employment and reduce sickness absence.

The most common causes of work related ill health are musculo-skeletal disorders (MSD), stress, respiratory disorders, heart disease, skin problems and infectious diseases. Evidence suggests that 40% of all sickness absence is due to musculo-skeletal injuries and 30% is due to mild/moderate mental health issues. Most physical causes of work absence are often accompanied by emotional and psychological problems which develop while on prolonged sick leave. Short term sickness accounts for 80% of absences and 62% of lost time. As the majority of absences are accounted for by minor complaints, the potential for management of these absences is even more apparent through earlier intervention.

What the vocational rehabilitation model does

The vocational rehabilitation model identifies the need for a rapid access referral process through which individuals can secure support and specialist advice from a dedicated vocational rehabilitation team consisting of a range of professionals that use case management approaches. The emphasis is to provide earlier intervention to reduce longer term sickness absence and assist those individuals within the workplace.

Testing the vocational rehabilitation model

There are three projects running currently in Tayside, Borders and Lothian to test this model in conjunction with the Scottish Centre for Healthy Working Lives. In each of the projects a dedicated team delivers vocational rehabilitation for small to medium enterprise businesses in these areas. The vocational rehabilitation project will link with related programme teams including the local Pathways To Work Condition Management Programme, Keep Well and Occupational Health Services Extra to provide a single point of access into these services with the aim of helping individuals to remain/return to active employment.

Volunteering

If a full return to work is not possible, someone might like to volunteer in some capacity. Volunteering can provide meaningful activity with opportunities for skills development and may lead to employment if the volunteer considers that to be appropriate for them.

There is a network of volunteer centres across the country and the national body for volunteering is **Volunteer Development Scotland**. Volunteers also make valuable contributions to the NHS and there is a 'Designated Person Responsible for Volunteering' in each NHS Health Board.

Food For Thought:

- How well do you link with your local vocational rehabilitation, Fit for Work and condition management services?
- Do you know who the Designated Person Responsible for Volunteering is in your NHS area?

MAXIMISING BENEFITS AND FINANCIAL HEALTH

Our shared aspiration is to design, develop and deliver services so that people are neither financially nor socially excluded from society as a direct consequence of their health. This requires that people with long term conditions, their carers and families:

- have systematic access to services which will assess and meet not just their medical but their wider emotional and social needs
- are enabled and supported to be an active participant in their care; playing as active a role in decisions about their treatment, care and support as they wish
- are supported to continue to play an active part in society and not excluded culturally, socially or financially
- are recognised and supported as key participants in this journey
- can navigate access to services and facilities which already exist in the local community, including library and leisure services.

To make this happen, health, social care, community and voluntary partners need to work together to be more responsive to the full needs of people.

What is already happening?

The Macmillan Model

In the past five years **Macmillan Cancer Support** has invested over £30 million to develop collaborative working between health, social care and third sector partners to provide new models of service for people living with cancer. The scale and impact of the Scottish Cancer Benefits Network is such that it is a proven model for partnership working between local government, NHS and the third sector. This support to address the social challenge that faces individuals and their families has already delivered significant improvements in the lives of people living with or beyond cancer. **Macmillan** aim to raise the profile of these services through **Long Term Conditions Alliance Scotland** (LTCAS) membership and beyond, building on the key principles of what has already worked for people with cancer.

The key principles

- Early, targeted and ongoing intervention with a focus on high volume groups.
- A team of advisors who are trained to understand the impact of a cancer/long term condition on a person's eligibility for benefits.
- Utilise the existing expertise, knowledge and networks within the Local Authority – augment where appropriate through formal training.
- Develop robust practices/protocols for the identification, referral and delivery of advice for everyone who is affected by a long term condition.
- Embed these practices within clinical processes to ensure they become a routine part of EVERY person's clinical journey.
- Develop a team approach between clinicians and advisors.

- KEEP IT SIMPLE – use what exists and bring these principles together to the benefit of those people who need it most.

Pilot sites in NHS Forth Valley and NHS Tayside have now been funded by the Scottish Government to develop the long term conditions approach to this model.

Chest Heart and Stroke Scotland (CHSS) funds welfare benefits advisors in Lanarkshire and Glasgow in partnership with **Citizens' Advice Scotland**. These services raised more than £795,000 in client financial gain over the last year. The model is being extended to Fife through work with Fife Citizens Advice and Rights Bureau. Other voluntary organisations have similar arrangements to support financial health.

The **Money Matters Service** has operated in partnership with NHS Greater Glasgow & Clyde to deliver financial inclusion support to people in the Keep Well programme. This includes benefit entitlement and maximisation, help with debts, advice on pensions and other savings.

Food For Thought:

- **Do you know how to signpost people to their local benefits advice and support services?**

MENTAL HEALTH IMPROVEMENT

Our mental health affects every aspect of our lives and can be thought of in two dimensions; mental health problems (e.g. anxiety and depression) and mental wellbeing. The concept of mental wellbeing includes both *how people feel* – their emotions and life satisfaction – and *how people function* – their self acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy. Many people with long term conditions have, or are at risk of having, mental health problems.

Mental health improvement is activity to promote good mental wellbeing in the general population; to reduce the prevalence of common mental health problems; and to improve the quality of life for people experiencing mental health problems or illness.

Practitioners delivering anticipatory care and supporting people with long term conditions are well placed to promote mental wellbeing and help prevent the development of mental health problems by helping people identify their emotional needs and signposting them to information, advice and support they need.

The Living Better Research Team have found that one in three people with diabetes and one in five with coronary heart disease (CHD) or COPD experience a range of emotional strains relating to their condition, including isolation, stress, fear, anger and frustration and would benefit from having "someone to talk to" to share ideas and advice on how to cope with their condition. However, it is estimated that half of people with mental health problems go undiagnosed.

Health Professionals often feel ill equipped to respond to these issues, or instigate conversations about mental health. The Living Better team have developed a half day training course on mental health awareness, assessment and signposting, aimed at primary care staff and specialist nurses. For further information, contact **pippa@sdcmh.org.uk**. Diabetes & Mood and CHD & Mood leaflets are available on the **Living Better Scotland** website.

Self Help

Self-help describes a range of approaches to help promote our mental health and prevent development of common mental health problems. These include social contact with others, positive thinking, physical activity, spirituality, creativity and learning and meeting in groups to share experiences and offer peer support. These groups tend to be user led, run and focus on mutual support but can also involve professionals. Further information on such self help approaches is contained in the NHS Health Scotland guidance note on ***evidence based messages to promote mental wellbeing***. Additionally, simple, clear, guidance on how to deal with stress is available via the **Steps for Stress** website.

Professionally developed resources for self help often draw on cognitive behavioural approaches like Living Life to the Full and use bibliotherapy or healthy reading schemes and booklets. NHS Fife Psychology and Public Health Departments developed **Mood Cafe**, a website to provide information about mental health, local and national resources and advice to support self help.

Healthy Reading Midlothian, a collaboration between NHS Lothian, Midlothian Library Services and Midlothian Wellbeing Interventions Network, provides access to evidence based self-help resources through local libraries and the Orchard Centre. For people with literacy, concentration or memory difficulties, the resources include books, audio books, DVDs and approved web links. Members of the public can access these as for any other library resource. As part of the service, health care professionals can issue a "prescription" for resources which can be redeemed through their local library.

Recovery

The **Scottish Recovery Network (SRN)** promotes recovery-based service delivery and self-directed approaches to recovery.

> *''being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life."*

Self-help tools and strategies include **Wellness Recovery Action Planning (WRAP)**. This focuses on developing self management plans, including the identification of 'warning signs' and identifying useful self-help strategies. The Scottish Recovery Network is supporting the use of WRAP in both individual and group settings in Scotland. WRAP training shifts the focus in mental health care from 'symptom control' to prevention and recovery. ***Realising Recovery*** is a resource for staff published in partnership with NES.

The Forfar Kirriemuir team are running Recovery Workshops in partnership with voluntary organisations and involving service users in their development and delivery. Moving forward in Angus covers self development and vocational rehabilitation.

Food For Thought:

- How well are you linked with your local mental health services?
- Do you know how to signpost people to local voluntary sector groups and support services?
- How might WRAP tools support your work?

LEARNING AND WORKFORCE DEVELOPMENT

"A Force For Improvement: The Workforce Response to Better Health, Better Care" (2009), describes a key ambition for NHS Scotland to be "ambassadors for health improvement, safety and quality, using every interaction with individuals, communities and populations, and every patient care episode to maximise their public health and education role".

It is clear that we need to prepare staff to:

- target and engage with individuals and with populations
- develop a better understanding of individual motivations for health behaviour change
- be able to provide continuous support through health coaching
- support people to self manage and to be the lead partner in their care
- develop the skills needed to work effectively with people from other sectors and organisations who may be better placed to offer the appropriate support

Getting to the point where a person really is the lead partner in their care requires a fundamental change in the relationship between the care provider and the person receiving care. For this reason the learning and workforce development needs associated with anticipatory care and self management place a strong emphasis on communication and human relationship skills.

The learning needs to support effective communication, consultation and human relationships are considerably broader than the acquisition of skills or knowledge. They extend to the development of clusters of different behaviours, traits, attitudes and skills. A recent review of staff working on long term conditions highlighted a complex pattern of overlapping and interconnected learning needs, and the importance of support for practitioners to develop the desired approaches and behaviours.

It is clear that the skills and behaviours associated with Self Management and Anticipatory Care are not entirely new and are certainly not 'technical'. Therefore it is tempting to feel that we are already competent in many of them. However, feedback from people receiving health care suggests that we aren't consistently using these approaches to positively impact on the experience of care. These are skills and behaviours which need to continually evolve and adapt. They require support in practice and leadership which models and values improvement in practice.

Developing the required skills and behaviours is a process which involves education, team learning and practice development. A key part of this process is learning from, and with, people who use services, live with long term conditions and who are from a range of community settings. It is important too to learn from, and with, other sectors and partners, particularly community organisations and voluntary agencies.

Many practitioners may have received training on these skills in different guises and may not be aware of transferable skills that they already possess.

The following table is a summary of core themes and approaches for staff working across both Anticipatory Care and Self Management. These will collectively support staff to develop an approach that improves health and wellbeing, reduces inequalities and enables people to have greater control over their conditions.

	Behaviours, actions and learning needs
Engaging with people	For example: working in partnership, developing person-centred skills, listening to and valuing the person's story and experience, focussing on the individual, how an individual's culture, belief and preferences affect their involvement and communication, working with local community and voluntary sector organisations who are already engaged with people.
Equality and diversity	Respecting, valuing diversity, developing working knowledge of equality and diversity practice; understanding individuals' values, beliefs and interests, promoting shared decision making.
Team working	For example, communication within and between teams and shared record keeping.
Self management	Moving away from 'doing' for people, supporting people to learn and work in partnership, managing risk, working collaboratively with user-led and voluntary organisations, assisting people to establish support networks
Promoting change	For example, negotiating the risks to health and well-being through motivational interviewing, changing health behaviour, shared decision making, identifying preferred styles of learning and empowering people.
Promoting health	Coaching, understanding equity and diversity, optimising mental health and social well being, promoting social inclusion, rights, interests and responsibilities, supporting spiritual wellbeing.
Care management	For example, assessment skills, developing outcome-focused care plans, reviewing progress against goals and having the confidence to make decisions.

Sharing resources and experience

There are a variety of training courses and resources for front line staff delivering anticipatory care approaches across Scotland.

Training Provider	Training Type/Resource	Aims
NHS Health Scotland	**Communication and Engagement Skills**	To reduce barriers and promote engagement of hard to reach groups.
	Behaviour Change and Health Inequalities	Develop practitioner skills in health behaviour change strategies.
	Train the Trainer	To train those who want to deliver the Improving Health: Developing Effective Practice course (IH:DEP).
NHS Health Scotland & Community Health Exchange	**Health Issues in the Community**	Increasing community capacity, increasing community participation, and establishing/ consolidating community development approaches to tackling inequalities in health.
Robert Gordon University	**Anticipatory Approaches in Health Care**	To understand anticipatory care approaches and to adapt working practices in accordance with such approaches.
NHS Education for Scotland	**Bridging the Gap – Tackling Health Inequalities**	To further understanding of Health Inequalities.
	Educational Database	Online catalogue of modules related to long term conditions.
	Supporting people with long term conditions to self manage	Identifies the core knowledge, skills and competencies/capabilities that enable health, social care and voluntary sector staff to support people to manage their conditions.
Thistle Foundation	**Lifestyle Management Course**	To make use of and build on participants' own recovery strategies and is designed around a framework of planned discussions, safe and appropriate exercise and therapeutic relaxation.
	Higher Education Certificates	To deliver a Higher Education Certificate in Person Centred Approaches.

Food For Thought:

- How do you creatively and realistically support people to integrate new learning into practice?
- How do you support work based learning?
- Have you developed any innovative ways of learning outside the traditional workplace? For example, voluntary sector placements?

Further References

Supporting Self Management

- *Gaun Yersel! Self Management Strategy:*
  http://www.scotland.gov.uk/Publications/2008/10/GaunYersel
- Long Term Conditions Alliance Scotland http://www.ltcas.org.uk/
  0141 404 0231
- NHS24 www.nhs24.com 08454 24 24 24
- *Developing Partnerships between Community and Voluntary Sector Organisations and Anticipatory Care (Health Scotland 2010.)* www.healthscotland.com/documents/3659.aspx

Health Inequality

- The Scottish Index of Multiple Deprivation, Scottish Government
  http://www.scotland.gov.uk/Topics/Statistics/SIMD/
  0131 244 3331
- *Equally Well: Report of the Ministerial Taskforce on Health Inequalities*
  http://www.scotland.gov.uk/Publications/2008/06/25104032/0
- Information Services Division (ISD)
  http://www.isdscotland.org/isd/CCC_FirstPage.jsp
- Keep Well
  nhs.healthscotland-keepwelladmin@nhs.net
- Equally Well
  http://equallywell.ning.com/
- *SPARRA Made Easy*
  http://www.isdscotland.org/isd/6072.html

Reach and Engagement

- NHS Health Scotland
  http://www.healthscotland.com/
- 'Strategies to Reach the Target Population. Interim Report'
  http://www.healthscotland.com/documents/3529.aspx
- Dundee Healthy Living Initiative
  http://www.dundeehealth.com/keepwell.htm

Health Literacy

- *New Light on Adult Literacy in Scotland (Scottish Government 2008)*
  http://www.scotland.gov.uk/Publications/2008/01/22131652/0
- Adult Literacies Online
  http://www.aloscotland.co.uk/alo/viewresource.htm?id=454
- Big Plus
  http://www.thebigplus.com
  0808 100 1080

- CLAN Health and Literacy Project, NHS Lothian
  Elspeth@clanedinburgh.org
  jo@clanedinburgh.org

- Literacies and Health, NHS Greater Glasgow & Clyde
  http://www.phru.net/literaciesandhealth
  Catriona.carson@ggc.scot.nhs.uk

- Healthwise Aberdeen
  http://www.healthwise-aberdeen.com
  info@healthwise-aberdeen.com

- Health Promotion Officer, NHS Ayrshire and Arran
  http://www.mhnayrshireandarran.org
  Lindsey.murphy@aapct.scot.nhs.uk

- Translation, interpreting and communication support
  www.healthscotland.com/.../11358-NHS%20Scotland%20TICS%20strategy%20October%202009%20(2).doc

Community-Led Health

- *'Community Engagement to Improve Health'; NICE Public Health Guidance 9.*
  http://www.nice.org.uk/nicemedia/pdf/PH009Guidance.pdf

- *'Healthy Communities: Meeting the Shared Challenge'*
  http://www.scdc.org.uk/shared-challenge/

- Community Health Exchange (CHEX)
  www.chex.org.uk
  0141 248 1990

- Community Food and Health Scotland (CFHS)
  www.communityfoodandhealth.org.uk
  0141 227 6463/6464

- Long Term Conditions Alliance Scotland (LTCAS)
  www.ltcas.org.uk

- Voluntary Health Scotland (VHS)
  www.vhscotland.org.uk
  0131 225 7290

Supporting people to return to or to remain in work

- Jobcentre Plus
  http://www.jobcentreplus.gov.uk/JCP/index.html

- Healthy Working Lives, NHS Scotland
  http://www.healthyworkinglives.com/
  0800 019 2211

- Fit For Work Services
  http://www.workingforhealth.gov.uk/Initiatives/fit-for-work-service/Default.aspx

- Condition Management Programmes, NHS and Jobcentre Plus
  www.jobcentreplus.gov.uk/JCP/stellent/groups/jcp/documents/websitecontent/dev_012591.doc

- Volunteer Development Scotland
  www.vds.org.uk

Maximising benefits and financial help

- Citizens Advice Bureau
  http://www.cas.org.uk/

- Chest Heart and Stroke Scotland
  http://www.chss.org.uk/

- Money Matters Service
  www.moneymattersweb.co.uk
  advice@moneymattersweb.co.uk

Mental health Improvement

- *NHS Health Scotland: Mental health improvement: evidence based messages to promote mental wellbeing*
  http://www.healthscotland.com/uploads/documents/5335-RE050FinalReport0607.pdf

- Steps for Stress
  http://www.infoscotland.org.uk/stepsforstress/

- Mood Café, NHS Fife
  http://www.moodcafe.co.uk/content.asp?ArticleCode=2

- Healthy Reading, NHS Lothian
  http://www.refhelp.scot.nhs.uk/dmdocuments/Prescribers_booklet.pdf

- Scottish Recovery Network
  http://www.scottishrecovery.net/content/

- Mental Health Recovery and WRAP
  www.mentalhealthrecovery.com/

- Living Better
  http://www.rcgp.org.uk/councils__faculties/rcgp_scotland/initiatives/living_better.aspx

Learning and Workforce Development

- *'A Force For Improvement: The Workforce Response to Better Health, Better Care'*
  http://www.scotland.gov.uk/Publications/2009/01/20121026/0

- NHS Health Scotland
  http://www.healthscotland.com/learning/index.aspx

- The Robert Gordon University
  http://www.rgu.ac.uk/health/cpd/page.cfm?pge=50127
- Educational Database, NHS Education for Scotland
  www.ltctraining.scot.nhs.uk/home.aspx
- Bridging the Gap, NHS Education for Scotland
  http://www.equalityinhealth.scot.nhs.uk
- Health Issues in the Community
  www.chex.org.uk/hiic
- Thistle Foundation
  http://www.thistle.org.uk/our-services/training-consultancy/hec-course

Links to information on specific groups

Black and Ethnic Minority Groups

- MECOPP Carers Centre
  www.mecopp.org.uk
- Black and Ethnic Minorities Infrastructure in Scotland (BEMIS)
  www.bemis.org.uk
- Council of Ethnic Minority Voluntary Organisations (CEMVO)
  www.cemvo.org.uk
- Ethnic Health Forum
  www.ethnichealth.org.uk
- Amina – Muslim Women's Resource Centre
  www.mwrc.org.uk
- Chinese Healthy Living Centre
  www.glasgowchlc.org

Children and Young People

- Action for Sick Children (Scotland)
  www.ascscotland.org.uk
- Contact a Family
  www.cafamily.org.uk
- Children in Scotland
  www.childreninscotland.org.uk
- Children 1st
  www.children1st.org.uk
- Scottish Traveller Education Programme (STEP)
  www.scottishtravellered.net

Travellers

- Delivering for Scotland's Gypsies/Travellers: An updated response to the Equal Opportunities Committee inquiry into Gypsy Travellers and Public Services 2001
  www.scotland.gov.uk/Resource/Doc/47251/0025026.pdf
- Friends, Families and Travellers
  www.gypsy-traveller.org/health

Learning Disability

- PAMIS
  www.dundee.ac.uk/pamis
- Turning Point Scotland
  http://www.turningpointscotland.com/
- ENABLE Scotland
  www.enable.org.uk
- Scottish Consortium for Learning Disability (SCLD)
  www.scld.org.uk
- Learning Disability and Ethnicity Network
  www.lden.org.uk

Migrant Workers

- Polish Information Plus
  www.polishinformationplus.co.uk
- Sikorski Polish Club
  www.scotpoles.co.uk
- Scottish Bulgarian Association
  www.scottishbulgarianassociation.org.uk

Asylum Seekers

- Scottish Refugee Council
  www.scottishrefugeecouncil.org.uk
- West of Scotland Regional Equality Council (WSREC)
  www.wsrec.co.uk
- Edinburgh and Lothians Racial Equality Council (ELREC)
  www.elrec.org.uk
- Central Scotland Racial Equality Council (CSRECL)
  www.centralscotlandrec.org.uk
- Grampian Racial Equality Council (GREC)
  www.grec.co.uk

Ex Offenders

- Turning Point Scotland
  www.turningpointscotland.com/services/criminal_justice
- Apex Scotland
  www.apexscotland.org.uk/area/asert.htm
- Families Outside
  www.familiesoutside.org.uk
- SACRO
  www.sacro.org.uk
- The Glasgow Partnership Project
  www.glasgowpartnership.ukf.net

Pan-disability

- Sense Scotland
  www.sensescotland.org.uk
- Disability Information Greater Glasgow (DIGG)
  www.digg.org.uk
- Capability Scotland
  www.capability-scotland.org.uk
- Inclusion Scotland
  www.inclusionscotland.org
- Scottish Disability Equality Forum
  www.sdef.org.uk

Mental Health

- Scottish Recovery Network
  www.scottishrecovery.net
- Scottish Association for Mental Health (SAMH)
  www.samh.org.uk
- Penumbra
  www.penumbra.org.uk
- Bipolar Fellowship Scotland
  www.bipolarscotland.org.uk
- Depression Alliance
  www.dascot.org
- National Schizophrenia Fellowship Scotland
  www.nsfscot.org.uk

Homeless People

- Keep Well
  www.healthscotland.com/documents/4529.aspx

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