Self care support:
A compendium of practical examples across the whole system of health and social care

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Contents

Key messages:

- There are many innovative practical examples of self care support across all settings.

- Few models have been formally evaluated although some are based on principles from published evidence.

- User input to the design and content of information and decision support is crucial if the resulting resources are to be credible, trusted and utilised. There are however some tensions in bringing together lay and professional sources of evidence on information sources.

- There is evidence of some gap between user and professional perspectives about the purpose of information and other facilities to support self care.

- Support and endorsement from doctors and other health professionals for self care is key to public 'buy in'. There are several high quality sources of information and other facilities to support self care that to which both professionals and service users have access. However, to achieve shared use of such resources would require awareness raising and sometimes training of professionals.

- Involving local people through all stages of community-based approaches helps to make programmes both more relevant and more sustainable.

- Several programmes involving peer health mentors, advisors and self care support networks are emerging (for example, in increasing physical activity among older people and healthy eating among children) and the principles of this model could be transferred to other areas of self care.

- Some models of internet-based self care for long-term conditions may currently be oriented rather more towards provider than patient agendas. Some effort is needed to develop partnership approaches.

- No examples were found where a 'whole systems' approach to self care had been taken across a health economy. There is scope to bring together key principles from different settings to design and test a whole systems approach.

- Organisations considering using the service models contained in this report will need to apply their usual risk assessment process.

- Further examples of innovative practice in support for self care will be welcome and should be sent to Ayesha Dost, Principal Analyst and Policy Adviser at the Department of Health at ayesha.dost@dh.gsi.gov.uk

1. Background

Self care involves active citizenry and public engagement; it is also about attitudes and behaviours. The working DH 'definition' of self care support and self care is as follows:

"Self care is a part of daily living. It is the care taken by individuals towards their own health and well being, and in their role as carers includes the care extended to their children, family, friends and others, whether in their homes, neighbourhoods, local communities, or elsewhere.

Self care includes the actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital.

Health and social services support for self care involves increasing the capacity, confidence and efficacy of the individual for self care and building social capital in the community by such means as:

- *appropriate and accessible advice. information and campaigns on lifestyle issues to change behaviours (such as physical activity, healthy eating, other behaviours to sustain well being and prevent ill-health) and to change the care of minor, acute and long-term conditions*
- *health education (such as adult health skills and health literacy programme of DfES)*
- *self care skills training, for example through the Expert Patients Programme*
- *first aid training in schools for children*
- *self-diagnostic tools, self-monitoring devices and self care equipment*
- *multi-media, multi-lingual self care facilities and information materials*
- *individualised care plans*
- *support networks of people with experience and memory of healthy living and of caring for a minor, acute or long-term condition*
- *active participation of the public locally and nationally in the formation and implementation of relevant local and national government policies and programmes*
- *education of the public and practitioners to change their attitudes and behaviours towards self care*
- *training of practitioners in when and how to use approaches to support self care*
- *work to develop partnerships between care professionals and the public to enhance shared care."* (Dost 1997)

Self care occurs in all settings, ranging from upstream in the home through all parts of the health and social care system to downstream, such as in intermediate or home care services. It *"includes decisions to do nothing, self-determined actions to promote health or treat illness, and decisions to seek advice in lay, professional and alternative care networks, as well as evaluation of decisions regarding action based on that advice"* (Dean 1986). The recognition that people need to be supported in making

their own decisions about health is clear in more recent descriptions of self care, which are explicit in identifying the patient as decision maker, using support where necessary. For example, self care is: *"A more inclusive concept based on the ideology of supporting patients in making their own wise decisions rather than offering an alternative decision maker" (Mullet J 2000).*

There are increasing signs that the public actively wants to learn more about self care (Dost 2000). The response to the NHS consultation on long-term planning for hospitals and related services, for example, showed that *"in terms of public education the respondents talked about people being encouraged to take control of their own well-being, employing self care, and taking preventative measures to improve their own health"* (DH 2003). For all of these reasons, self care has risen in prominence within many health care systems. In the UK the DH has been developing self care policy for several years (see, for example, Royston 1998, Dost 1997, 2000, 2005). Enhancing capacity for self care was a key building block of the NHS Plan and 'Building on the Best' gave specific commitments about ensuring that patients have a greater say in decisions about treatment and that the NHS extends its information provision to support those decisions (Department of Health 1999; Department of Health 2003). Support for people in decision making to improve health is a key element of 'Choosing Health' (Department of Health 2004). Self care is also a key component of the 'Model for Supporting People with Long Term Conditions' (Department of Health 2005).

Self care is central to health care system developments in other countries such as Canada and the US (Mayo Clinic, USA, 2003). In Canada, a five year programme to involve health professionals in supporting self care was completed in 2002 (Canadian Nurses Association 2002).

As stated in this compendium at the outset, an integrated programme to support self care can empower people to take a more active role in taking care of their health and to:

- take steps to prevent ill health and promote good health
- recognise non-serious health symptoms and deal with them with use of formal health and social care services only when necessary
- recognise serious health symptoms and seek advice quickly
- take care of own health during rehabilitation after a serious illness
- self care for long-term conditions.

This compendium sets out to draw together evidence from service models in the UK and elsewhere, together with published articles and reports, to consider how self care support models might be more widely transferred and used.

The scope of self care support and self care is wide ranging and incorporates activities to *"enhance health, prevent disease, evaluate symptoms and restore health" (Dean, 1986)*. The examples identified for this report covers all four areas and all parts of the health and social care whole system (Dost 2005). See Appendix 1 at the back of this

compendium. In addition to considering activities generated by the individual it also considers activities taught or supported by health and social care professionals. Learning and re-learning aspects of self care is, for example, an important component of intermediate care rehabilitation services that aim to promote safe and independent living at home for those patients for whom this is possible.

Self care support for people with long-term conditions has become an important component of strategies within the NHS and elsewhere. In particular self care skills training programmes have gained increasing recognition. Such programmes have been developed and led by peers and by health professionals. Recent research points out that *"health professionals have created structures in the approach to patient education whereby people are positioned as passive subjects absorbing information. In contrast . . . self-management is a dynamic, active process of learning, trialling and exploring the boundaries created by illness"* (Kralik et al 2003*).* The implied gap between care professional and lay views of self care serves to highlight the importance of user involvement in the development of interventions intended to empower and enable people with long-term conditions.

The aim of this compendium is to identify and describe approaches to self care support across all the settings in the whole system of health and social care.

Objectives

- Increase awareness of the scope of self care support and of existing (past, recent, current and likely future) developments.
- Illustrate examples of innovative service and practice developments.
- Identify where self care support contributes or might contribute to achieving NHS targets.
- Encourage wider dissemination and uptake of self care support models.

2. Methods

Several methods are used to identify self care support initiatives, models and materials for potential inclusion in this compendium.

i. Key stakeholders were asked to identify service models.

ii. Research databases were searched for publications providing evidence from trials of different models of self care support.

iii. A wider internet-based search was undertaken to locate 'grey literature', including reports of studies and service developments of self care support as well as websites providing ideas on self care support. Key search terms used include self care, self help and self-management together with different home, health and social care setting terms.

The findings using all three methods are tabulated. Although the intention is for the main focus to be on UK initiatives, those from other countries that appeared to offer a novel element are also included at this stage. The various initiatives are compiled and divided into two groups: one is called "case studies" which provides various details on outcomes and contact names; the second group called "examples" gives the basic idea on the type of innovative and relevant self care support ideas possible to take on board locally.

Contact has been established with a key informant at each of the initiatives selected as case studies. Further information has been obtained using telephone interviews, site visits where relevant, and structured email requests. The framework used to construct case studies from the various initiatives is at Appendix 2. Each key informant has been offered the opportunity to review the draft case study text prior to inclusion in the report.

Case studies are presented in shaded boxes ☐ with solid borders to distinguish them from examples of self care support initiatives. Examples are in shaded boxes ⬚ with dotted borders.

Relevant reports and selected articles are listed and summarised in Appendix 3.

3. Tables summarising the self care support examples

Fifty examples are identified. The types of examples are summarised in Table 1. A brief description of each is presented in the relevant section of the report. Some of case studies have kept data on usage and some have been formally evaluated.

Table 1: Settings and numbers of innovative service examples

Setting	Number of examples described	Case studies included
Home-accessed information provision and decision support	12	4
Community settings	11	6
Workplace and pre-retirement	4	2
Community pharmacies	2	1
General practices in primary care	2	1
Emergency care	5	2
Hospital outpatients	3	2
Hospital day cases	1	-
Hospital inpatients	2	1
Podiatry	1	1
Intermediate care	3	2
Residential and nursing homes	1	1
TOTAL	**50**	**23**

Table 2: Summary of case studies by country, health area (prevention, promotion and lifestyle; minor ailments; acute illness; long-term conditions), population group and setting

	Country	Prevention & lifestyle	Minor ailments	Acute illness	Long-term conditions	Population group	Setting
Proactive outreach support in asthma	UK				♦	All	Home
DiPEx	UK				♦	All	Home
BestTreatments	UK		♦	♦	♦	All	Home
Healthy communities	UK	♦				All	Community
Community-led weight management	UK	♦				Adults	Community
Self care, Independence, Nutrition & Education (SCINE)	UK	♦				Adolescents	Community
'Up for It' programme	UK	♦				Adults & children	Community
Peer Activity Motivators	UK	♦				Older people	Community
Bug Investigators	UK		♦	♦		Children	Schools
Pitney Bowes Health Care University	US	♦			♦	Workers	Workplace
Pre-retirement peer health advisors	UK					Workers	Community
Sure Start – Pharmacy collaboration	UK		♦	♦		Mothers & children under 4	Community pharmacies
Green Gym & Health Walks	UK	♦				All	GP practice and Community
NHS Direct in A & E	UK		♦	♦		All	A & E
NHS Direct and non-serious 999 calls	UK			♦		All	Ambulance service
Moving More Often	UK	♦				Older People	Residential and Nursing Homes; Sheltered Housing
Foot Care	UK	♦	♦			Older people	Community
Pre-operative patient education	Australia			♦		All	Hospital
Diabetes education	UK	♦			♦	All	Hospital outpatients
Falls prevention education	UK	♦				Older people	Hospital outpatients
Pre-discharge heart failure education	UK	♦			♦	All	Hospital inpatients
Intermediate care co-ordination centre	UK	♦				Older people	Intermediate care
Homeward Bound Units	UK	♦			♦	Older people	Intermediate care

Table 3: DH and NHS Targets to which self care might contribute

In considering the potential contribution of self care to the NHS, firstly NHS targets[1] to which self care might contribute are identified, then relevant examples of innovative practice are mapped against them.

PRIORITY AREA		TARGET	Report section
Improve the health of the population	Heart disease, stroke and related diseases	Reduce mortality rates from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	4.1.3, 4.2.1, 4.2.2, 4.2.3, 4.2.4, 4.3, 4.6, 4.11
	Cancer	Reduce mortality from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	4.1.3, 4.2.1, 4.2.2, 4.2.3, 4,3
	Obesity	Halt the year on year rise in obesity in children under 11 by 2010.	4.2.1, 4.2.2, 4.2.3, 4.2.4, 4.4, 4.6, 4.8, 4.11
	Teenage pregnancy	Reduce the under-18 conception rate by 50% by 2010.	4.7
Patient /User experience	Improve the quality of life and independence of vulnerable older people by supporting the to live at home wherever possible	Increasing by March 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	4.2.2, 4.2.4, 4.8, 4.9, 4.10, 4.13
		Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008.	4.2.2, 4.2.4, 4.8, 4.9, 4.10
Patient /User experience	Involvement of individuals in decisions about their heathcare	Secure sustained improvement in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care	4.1.1, 4.1.2, 4.1.3, 4.2.2, 4.2.4, 4.10, 4.12
Supporting people with long term conditions	Care plans	Offer a personalised care plan for people with long term conditions who are at higher risk	4.10, 4.12
	Emergency admissions	Reduce emergency bed days by 5% by 2008.	4.2.1, 4.2.2, 4.8, 4.9, 4.10, 4.11, 4.12
	Coronary heart disease	By March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking; also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.	4.6, 4.10
Access to services	Primary Care Access and Services	All patients to see GP within 48hrs and other primary care professional within 24hrs	4.1.1, 4.1.2, 4.1.3, 4.4
	Emergency and Acute service access	No one to wait more than 4 hrs in A & E from arrival to admission, transfer or discharge	4.1.1, 4.1.2, 4.1.3, 4.7

[1] Targets specified in the NHS Planning Framework 2005-2008 (National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005-6 – 2007-8)

Table 4: Self Care contribution to nGMS

The outcomes of support for self care can also help to deliver on the nGMS contract. Table 4 maps the case studies against the care of long-term conditions requirements of the QOF as well as against demand management by encouraging use of other models for the care of minor ailments.

nGMS area	**Case studies**
Transfer of consultations for minor ailments	4.1.3 BestTreatments
	4.2.5 'Bug Investigators' schools pack and antibiotic resistance
	4.4 Education and advice from community pharmacists for children's minor ailments
	4.9 Self care programme on basic foot care
Quality & Outcomes Framework (QOF)	**Case studies**
Secondary prevention in CHD	4.1.3 Directory of Patient Experience (Heart failure)
	4.1.3 BestTreatments (Heart attack, high cholesterol, smoking)
	4.2.3 'Up for It' health and lifestyle scheme
	4.2.4 Peer activity motivators
	4.6 Green Gym and Health Walks
Stroke or TIAs	4.1.3 BestTreatments (Stroke prevention; Stroke emergency care)
Hypertension	4.1.3 Directory of Patient Experience (High BP)
	4.1.3 BestTreatments (High blood pressure)
	4.2.4 Peer Activity Motivators
	4.6 Green Gym and Health Walks
Diabetes	4.1.3 BestTreatments (Diabetes)
	4.1.3 Pro-Wellness system for care of diabetes; D-net diabetes self care
	4.2.4 Peer Activity Motivators
	4.6 Green Gym and Health Walks
	4.10 Diabetes education
COPD	4.1.3 BestTreatments (COPD, Emphysema)
Epilepsy	4.1.1 Patient guide to medication review
	4.1.3 Directory of Patient Experience (Epilepsy)
	4.1.3 BestTreatments (Epilepsy)
Cancer	4.1.3 Directory of Patient Experience (Breast, bowel, cervical, lung, prostate, testicular)
	4.1.3 BestTreatments (Bowel, colon, lung, melanoma, ovarian, pancreas, prostate, rectal, skin)
Mental Health	4.1.3 Directory of Patient Experience (Depression)
	4.1.3 BestTreatments (Anxiety, Depression)
Asthma	4.1.2 Proactive telephone based outreach support
	4.1.3 BestTreatments (Asthma)
	4.3 Pitney Bowes Virtual Healthcare University

Table 5: Likely outcomes from self care support

Based on the evidence from the case studies, Table 5 summarises the likely outcomes from supported self care.

	Group	**Setting**	**Likely outcomes**		
			Patients / Public	**NHS**	**PSA Targets**
Proactive telephone based outreach support for people with asthma	All	Home	Increased knowledge Improvement in user experience	More effective use of consultations Increased self care of asthma Increased number of smoking quitters Improvement in user experience Reduced use of services medium and long term	
DiPEx	All	Home	Increased knowledge	More effective use of consultations	
BestTreatments	All	Home	Increased knowledge	More effective use of consultations	Improvement in user experience
Healthy communities	All	Community	Increased social capital Improved nutrition Reduction in falls	Reduction in admissions from falls	Reduction in waiting time for admission to hospital
Peer Activity Motivators	Older people	Community	Increase in physical activity Reduction in obesity Reduction in depression / improvement in mood Increase in skills to train and support others Increased social capital through involvement of volunteers	Reduced service use medium and long term	Increase in life expectancy
Community-led weight management	Adults	Community	Reduction in obesity Increased physical activity Reduced depression / improved mood Increase in self care skills Increase in skills to train and support others Increased social capital	Reduced service use medium and long term	Increase in life expectancy

	Group	Setting	Likely outcomes		
			Patients / Public	**NHS**	**PSA Targets**
Self care, Independence, Nutrition and Exercise (SCINE)	Adolescents	Community	Reduction in obesity Increased physical activity Reduced depression / improved mood Increase in self care skills Increase in skills to train and support others Increased social capital	Reduced service use medium and long term	Increase in life expectancy
'Up for It' programme	Adults & children	Community	Reduction in CHD risk factors Increased number of smoking quitters Increased physical activity Reduced depression / improved mood Reduction in obesity Improved ability to cope with stress	Reduced service use medium and long term	Reduction in mortality Increase in life expectancy
Bug Investigators	Children	Schools	Increased knowledge Reduced demand for antibiotics	Reduction in consultations Reduction in use of antibiotics	
Pitney Bowes Health Care University	Workers	Workplace	Increased knowledge Increased self care of long-term conditions	Reduction in health service usage	
Pre-retirement peer health advisors	Workers	Community	Increased social capital Increased understanding of appropriate use of services Increase in skills to support others	More appropriate service use	Improvement in user experience
Sure Start – Pharmacy collaboration	Mothers & children under 4	Community pharmacies	Improved and more appropriate access to health professionals in primary care	Reduction in GP consultations Increased use of pharmacists	
Green Gym & Health Walks	All	GP practice & community	Reduction in obesity Increase in physical activity Increased social capital	Reduced service use in the medium-long term Increase in life expectancy	Increase in life expectancy
NHS Direct in A & E	All	A & E	Improved and more appropriate access to health professionals		
NHS Direct and non-serious 999 calls	All	Ambulance service	Reduction in unnecessary hospital attendances	More appropriate and efficient use of ambulances	Reduction in waiting time for admission to hospital

	Group	Setting	Likely outcomes		
			Patients / Public	**NHS**	**PSA Targets**
Moving More Often	Older People	Residential & nursing homes; sheltered housing	Increased confidence Fewer falls Increased physical activity	Reduction in hospital admissions due to falls Increase in life expectancy	Increase in life expectancy Improvement in user experience
Intermediate care co-ordination centre	Older people	Intermediate care	Increased confidence Maintained independence Increased satisfaction with health services	Reduction in hospital admissions due to falls Maximise capacity of acute hospital beds	Reduction in waiting time for admission to hospital Improvement in user experience
'Homeward Bound' units	Older people	Intermediate care	Maintained independence Increased satisfaction with health services	Reduction in hospital readmissions Maximise capacity of acute hospital beds	Reduction in waiting time for admission to hospital Improvement in user experience
Foot Care	Older people	Community	Increased knowledge Increase in skills to support others Increased social capital through use of volunteers	Reduced demand for non-urgent chiropodist appointments	
Pre-operative patient education	All	Hospital	Increased awareness of significance of post-operative changes Increase in skills to support others	Reduced delay in consultation about post-op complications	Reduction in waiting time for outpatient appointment
Diabetes education	All	Hospital	Increased knowledge Increased confidence Increased active self care by people with diabetes	More effective use of consultations Reduced service use in the medium-long term Increase in life expectancy	Improvement in user experience
Falls prevention education	Older people	Hospital outpatients	Increased confidence Fewer falls Increase in skills to support others	Reduction in readmissions due to falls	Reduction in waiting time for admission to hospital
Pre-discharge heart failure education	All	Hospital inpatients	Increased understanding of the need for self care activities Increased active self care by people with heart failure Increase in skills to support others	Reduction in delays in instituting measures to prevent exacerbations Reduction in readmissions due to exacerbations Reduction in mortality	Reduction in mortality Improvement in user experience

4. Case studies and examples

4.1 Information and decision support

4.1.1 Print sources

Family networks for advice on self care may be both less available and less used than historically in the past. The ability to access advice and reassurance from home is therefore of increased importance. Self care reference books and booklets have been widely used, particularly in the US and Canada. Insurance companies and employers have evaluated their usage and have also measured changes in medical claims costs and use of health services. User surveys indicate the books to have been well-received and used. Several companies reported reduced use of health services (Mayo Clinic 2003).

Telephone based decision support, web-based information and written information in an integrated system have been evaluated in large-scale projects in Canada and the US. The effects of these programmes are summarised below. Overall, the findings from the evaluations indicate a reduction in emergency room usage for self-limiting conditions. The length of the evaluation periods varied, with some being relatively short (6 months) and therefore less likely to show the full effects of a programme intended to change behaviour. Considerable numbers of participants visited their doctor for reassurance that they had 'done the right thing', or that their condition was 'cured'. The importance of support from doctors for self care is highlighted in these studies.

Self Care Support Programme	**Components**	**Key findings**
Partnerships for Better Health Canada 1997-1999 Mullett J. (2000) Partnerships for Better Health: a self care pilot project. British Columbia. Ministry of Health. ISBN 0-7726-4258-3	Healthwise Handbook Nurse-led Health Support Line Newsletter on seasonal health problems	Participants reported use of handbook was high Teachers used the manual in schools Participants' intention to use self care increased Intent to visit emergency room decreased from 30.5% to 13.4% after advice from Health Support Line Compliance with self care advice from the Health Support Line was 84% Patients self-reported doctor visits were reduced Some participants visited doctors for reassurance that they had done the right thing. Recommended greater involvement of doctors in distributing the handbook and endorsing self care.

Healthwise communities Self care demonstration project 2 projects – Idaho and Oregon USA 1995-2000	Public awareness campaign Healthwise Handbook Workshops for community groups and health professionals Nurse-led telephone information line Healthwise Information Stations in libraries, clinics and work sites 'Replication' materials	Reduced utilisation of 'unneeded' health services – emergency room and doctor visits in Year 2 (Idaho). No significant decrease in primary care visits during 6-month follow-up (Oregon). Participants showed increased use of self care manual (Idaho + Oregon). Self care manuals may increase appropriate use of doctor consultations (Idaho). Any cost savings were relatively small (Idaho)
United Healthcare pilot programme USA Rector TS, Venus PJ, Laine AJ. American Journal of Managed Care 1999 (Dec); 5 (12): 131-138	Self care booklet (First Look) mailed to Medicaid patients, text at 4th grade reading level Telephone support to choose a personal physician Toll-free nurse-led helpline	No significant reduction in emergency room visits.

- The print version of NHS Direct's 'Not Feeling Well' will become available to households through the Thomson Local Directory. This offers the opportunity for co-ordinated support.

- Print-based information to support patients with specific conditions has been produced by a range of providers. The extent to which such information is used and acted upon by readers will depend on factors including their trust in the source. The importance of lay input to the development of information resources is increasingly recognised.

Guidebook to increase patient involvement in the care of colitis

A guidebook was developed to support self care & to mediate patient-doctor interaction during consultations for ulcerative colitis. The first part of the guidebook provided evidence and information, drawing on both traditional sources of evidence and also lay knowledge and experiences in describing the disease, its impact on patients and a discussion of treatment options in 'Your Choice' sections. Evaluation showed that the guidebook was rarely used as intended during consultations as physicians did not encourage it and patients were conscious of time pressures (Kennedy and Rogers 2002).

Patients' and doctors' had different views about the usefulness of the guidebook. Patients were keen to find out more about the condition and treatments and to hear the experiences of others. In contrast doctors saw the functions of the guidebook as to increase patients' compliance and to help patients make more appropriate use of services. The authors conclude that these findings *"indicate the need to more fully incorporate lay knowledge and experience into information on self care".*

- Patient support groups, charities and self-help groups are also providers of information to support self care. The **'Know Your Numbers'** concept aims to enable patients to know more about test results and their meaning in specific conditions so that they can take a more active role in monitoring their own treatment.

'Know your numbers'

A survey of National Kidney Federation members showed that almost half had never heard of national targets for 'numbers', one fifth had never discussed what a 'normal' result would be for their regular haemoglobin test or any other 'numbers' with doctors. Almost 90% said they would like printed information about the numbers. In response the National Kidney Federation produced a card, 'Know Your Numbers' which shows recommended levels for haemoglobin, calcium, phosphate and other biochemical markers together with blood pressure. The card makes clear where ranges may depend on local laboratory figures.

The card can be printed and downloaded from
http://www.kidney.org.uk/Medical-Info/other/know_nos.html

- The national PCT patient survey in 2003 showed that many people who are taking prescribed medicines want more information about them. Raising awareness about opportunities to have a review of their medicines provides a way of engaging patients in a discussion in which they can raise questions and concerns. In turn this will allow patients to take a more active role in managing their treatment.

Patient's guide to medicines review

Research for the Medicines Partnership showed that although few people had experienced a review of their medicines, most of those that did found it extremely helpful. In particular they valued the opportunity to discuss and ask questions about their medicines. In response Medicines Partnership Centre, in collaboration with several patient groups, has produced a patient's guide to medication review in the form of an 8-page booklet, 'Focus on your Medicines'. 500,000 copies have been distributed via patient groups, Age Concern and PCTs. The booklet raises awareness about the purpose and benefits of medication review and helps those patients who want to play a more active part in reviewing their medicines to do so by preparing concerns and questions before a review meeting.
Medicines Partnership, working with Epilepsy Action, the National Society for Epilepsy and Epilepsy Bereaved, has also developed a patient guide to review consultations in epilepsy, due for launch later this year. The guide tells patients what they need to know about review sessions, covering not only medicines but also other aspects of this specific condition, and helps them to prepare for a review by completing a diary of their condition and preparing their issues in advance

Contact: Joanne Shaw, Director, Medicines Partnership
Email: jshaw@medicines-partnership.org
http://www.medicines-partnership.org

4.1.2 Telephone-based services

The NHS Direct telephone service, which received over 500,000 calls per month in 2003-4, routinely advises callers to undertake self care as one of the dispositions from its Clinical Assessment System (CAS). A survey of 2778 callers found that 33% were given self care advice and over 80% of respondents reported that they had followed the advice. Overall 40% of callers said they had not gone on to use any other health services following their call.

Telephone based outreach care for people with long term conditions is an emerging model to support people with long term conditions.

Case study: Proactive self care support for people with asthma

50 GP practices in 25 PCTs are participating in 'Asthma Care', a proactive telephone outreach service to support self care. Individual patients are contacted by a nurse in a series of regular calls to discuss their asthma and related issues. Smoking cessation advice is also given. A key component of the programme is explanation of the importance of preventer therapy, and where reliever therapy fits in. Overall, around one third of patients contacted by the service did not appear to have an action plan for their asthma. Patients were referred to their asthma nurse or GP where needed. An evaluation was conducted with 150 patients who have completed the programme; 86% said they had a better understanding of their asthma and 69% reported an improvement in their asthma. When asked about their use of medicines 39% said that their compliance with preventer medicine had improved, and 40% said they had reduced the amount of reliever medicine they took. Feedback from patients about the service was positive. A key issue was that patients felt they had time to raise and discuss their questions in a way that they perceived was not possible in usual GP or asthma clinic appointments. Knowing that there would be further calls, also gave patients the confidence that they could raise further issues if they occurred.

Contact: Rosalind Grant, Head of Medicines Management, Bath and North East Somerset PCT; Email: Rosalind.Grant@banes-pct.nhs.uk

Likely outcomes:

Patient/Public
Increased knowledge
Improvement in user experience

NHS
Increased self care of asthma
More effective use of consultations
Reduced service use medium and long term
Increased number of smoking quitters

4.1.3 Internet and other technologies

Decision support for acute episodes of illness is available in a set of algorithms on NHS Direct Online. Access points include a map of the body so that users can point and click on the affected area.

- A number of high quality websites provide information to support people with long-term condition. The DiPEx site contains text, audio and video clips of patients' own accounts of their illness.

Case study: Directory of Patient Experience (DiPEx)

DiPEx (www.dipex.org) brings together patients' experiences, in their own words, on illnesses including cancers, hypertension and epilepsy. Patients discuss what diagnosis and treatment was like for them, how they live with their illness and how it affects their daily lives and those of their family and friends. DiPEx aims to be a resource for both patients and health professionals.

The website, which was set up in 2001, contains interviews with everyday people about their own experiences of serious illness or health problems. DiPEx works with researchers to conduct these interviews with patient volunteers. Website users can access the information by reading text, listening to audio clips or watching video clips. A leaflet about each health topic can be requested. The site has an interactive forum (set up in late 2003) where users can post their own stories and ask questions. Usage of this section is slowly increasing.

DiPEx is a registered charity. It has an ethical funding policy and does not accept funding from drug companies or have commercial advertising on the site.

The site averages 300,000 hits per month and since the start of 2004 has been able to collect more robust data on usage and referrals from other sites (300 patient and support group websites have links to DiPEx). Analysis of usage for the first two months of 2004 showed Colorectal Cancer to be the most frequently visited topic.

Future plans include reaching out to disadvantaged groups and ethnic minority communities, and the organisers believe that making DiPEx available in settings such as public libraries and information centres where help is available will enable those unfamiliar with the technology to share in the benefits.

Recently-published topics include heart failure, heart attack. New topics due to be published on the site during 2004 include

- Sexual health for young people (target group 18-25)
- Chronic pain
- Depression
- Ante-natal screening
- Arthritis
- Breast screening
- Ovarian cancer
- Dementia

DiPEx contd …

A new teenage health site with information tailored and designed by young people will be ready in early 2005 and its first topic will be teenage cancer. Focus groups with ill and healthy 13-18 year olds have been held to develop the site.

An evaluation study with patients with cancer showed that:

- Participants liked the combination of reliable health information and patient perspectives available on the DiPEX website. Having access to the information 24 hours a day 365 days a year was important as information was often needed at times when no professional was available to supply it.
- Many people felt that having access to the experiences of others through the website at the time of their illness would have reduced worry, fear and isolation, assisted with decision-making about treatment, and improved communication with health professionals as patients would have been better informed and better prepared to make the best use of limited consultation time.
- Being able to benefit from the experiences of others without having to enter into direct personal contact at a difficult time was highly valued particularly by those who didn't care to attend support groups, those for whom shyness, embarrassment, or reluctance to seek information face to face were a factor, and those who did not wish to burden a cancer patient with questions.
- People with limited or no computer/internet experience found the website approachable and several said that it had encouraged their interest in computers. Experienced users offered suggestions for improvements to design and usability but overall liked the website.

An independent evaluation will be carried out during 2004.

Contact: Jane Williams, DiPEx; Email: jane.williams@dipex.org

Likely outcomes:

Patients/Public
Increased knowledge

NHS
More effective use of consultations

- An important gap in provision has been access for patients to evidence-based information to which professionals already have access. Clinical Evidence has been produced by BMJ Knowledge since 1999 and is available free of charge via the National Electronic Library for Health. However as it was designed as a reference source for health professionals it was not user-friendly for patients. The development of a patient version of the evidence base together with contextual information about different illnesses and conditions, **BestTreatments**, will be available on NHS Direct Online.

Case study: BestTreatments on NHS Direct Online

From April 2004 patients have been able to access evidence-based information on 60 conditions and surgical procedures via NHS Direct Online. The conditions covered range from minor ailments such as athlete's foot and hay fever through to long-term conditions such as hypertension and asthma.

BestTreatments uses content from Clinical Evidence, a British Medical Journal publication originally produced for doctors. This is the first time that patients will be able to access the same information and evidence as their doctor. For each topic the user can access information about the condition and the evidence about available treatments. Evidence is arranged under a series of headings from "Treatments that work", through "Treatments where further research is needed" to "Treatments with more harms than benefits".

BestTreatments offers an opportunity for patients and health professionals to access, use and discuss the same information.

www.nhsdirect.nhs.uk

Likely outcomes:

Patients/Public
Increased knowledge

NHS
More effective use of consultations

PSA Targets
Improved user experience

- '**Understanding NICE Guidance** – Information for people with heart failure, their carers and the public'. In July 2003 NICE issued the first resource aimed at patients and carers, alongside the clinical guideline on care of heart failure. The document includes an explanation about what heart failure is, diagnosis, commonly used treatments, exercise and surgery.

- Satellite TV channels show promise in supporting self care. Pilots of the **NHS Direct digital television service** showed high uptake among otherwise hard to reach groups including young men and low-income families. The pilots also found that *"users are likely to be satisfied with the information they can access through digital TV, and to use it as an adjunct or even a replacement for visiting their doctor"*. Content for the service will include health conditions and treatments, medicines, health advice for travellers, health and safety advice and details of local NHS services (Department of Health 2003: Developing NHS Direct).

- Internet-based self care of long-term condition allows people to take a more active role in monitoring and maintaining their own health. 'Red flags' (potentially serious situations) can be referred immediately for further treatment or advice and are identified during monitoring by case managers. It has been argued that a barrier to wider use of such programmes is that "physicians have not received sufficient information to convince them that they can provide higher quality care by using the internet" (Forkner-Dunn 2003). Three examples of **web-based programmes for diabetes** are described below.

Pro-wellness Diabetes Care System

A web-based programme for care of Diabetes produced by Pro-Wellness (www.prowellness.com), a Finnish company producing systems for care of people with long-term conditions, and occupational health systems. The system integrates a clinical system for professional use with self care tools and can be used for remote monitoring of long-term conditions.

The patient can send blood glucose measurements via a modem or mobile phone and can access the system to monitor readings. The patient can use the Self care System to view reports and graphical representation of their results. If the patient wishes, their care team can view the home diary via the Internet. This information can be used in the clinic or when clinical staff are advising the patient over the phone or by email.

Within the NHS the system is being trialled from a hospital setting at Hillingdon and has recently been purchased by Westminster PCT for practice-based use. The London Diabetes and Lipids Centre (in association with Bayer) has 150 patients enrolled on the system.
http://www.prowellness.com/pw/english/frontpage_en.htm

The D-Net diabetes self care programme

Internet-based self care of diabetes was tested in a randomised controlled trial with 320 patients with Type 2 diabetes in the US (Glasgow et al 2003). The basic internet model was of information provision and the trial tested the addition of two components: tailored self care training and peer support. The findings showed that there were improvements in behavioural, psychosocial and some biological outcomes. Participant website use declined over time and the addition of the tailored self care and peer support components did not consistently improve results, suggesting that further testing is needed.

The 'Living with Diabetes' programme

This US-developed web-based programme supports the care of patients with Type 2 diabetes. It targets 4 key domains: self care support for people; delivery system design; clinical information systems; and clinical decision support.

A qualitative evaluation was undertaken in which depth interviews were conducted with nine patients before and after they used the programme (Ralston et al 2004). The programme offered patients access to their electronic record, secure email, opportunity to upload blood glucose readings, an education site with endorsed content, and an interactive online diary for entering exercise, diet and medication.

There were three key themes from the findings. The first was that patients appreciated their non-acute concerns being valued. They knew that they could email with questions and concerns and that their health care provider would answer in due course. Patients appeared to feel that this enabled providers to prioritise their query in the context of other patients' needs. The second area was patients' feelings of security. By interacting with the programme by entering their blood glucose data and lifestyle information, patients felt the health care system could 'watch over them' better.

However this in itself could create a problem if there was a mismatch between the expectations of patients and providers. The findings showed that before and during the use of web-based care of people with long-term conditions, patients and providers should discuss what the programme can and cannot deliver. The researchers conclude that bigger trials of web-based systems are warranted.

- Telemonitoring of patients at home is an area of current development. Philips, for example, is providing such a service for patients with heart failure in Southern California, which is being evaluated.

The Health Buddy: Feedback from patients

The Health Buddy (HB) is a device that connects to the internet and enables two-way communication between the patient and a care provider. This is a model that is provider-driven and intended to make case care more efficient and less intrusive (the alternative would be a daily telephone call from a nurse to ask the same questions). The patient responds to a short automated survey of about 12 questions by pressing buttons on the HB. The nurse case manager reviews the patient's responses each day and intervenes where necessary. Some of the daily surveys also included educational items on self care through a series of quizzes.

The Rand Corporation evaluated patient acceptability of the Health Buddy in people with heart failure (Bigelow et al 2000). Most patients found the device easy to set up and use. Most patients (well over 80%) met the criteria for compliance in responding to the daily survey and most gave positive reports about the device. However some patients consistently did not respond and overall around 20% dropped out of the programme early. Most of the patients who participated said their understanding of heart failure had improved and that they felt more confident in self care. The evaluation found that there was scope to extend the educational component of HB.

http://www.rand.org/publications/MR/MR1232/

4.2 Community-based approaches

Community-based support for self care may be based within families, schools, workplace, and religious and other community organisations.

4.2.1 Community involvement

The Healthy Communities Collaborative was set up in 2002 in three areas (Gateshead, Easington and Northampton) and has since been introduced in a further eight areas. The initial focus was on falls prevention and the first wave sites have now moved on to work on widening access to a healthy and affordable diet.

Case study: Community involvement in Gateshead

Gateshead was one of three pilot areas selected for the Healthy Communities Collaborative in 2002. Local teams were set up with the intention of bringing together local people with health staff, council staff and voluntary sector staff. The vision was to move away from a medical model of falls prevention and to empower local communities to take action on local issues. The teams were roughly 50% local people and 50% others and included local people, lunch club organisers, wardens of sheltered housing, home carers, Age Concern, Live at Home, CPNs, OT, Physios, a hospital link person, care home staff, community education and health, and council partnership staff.

The team came up with ideas and decided on local priorities to improve the health of older people with a focus on falls but also wider. Some of the work done subsequently was:

- Promotion of long life light bulbs
- Provision of battery-operated lights to reduce falls during power cuts in the dark
- A 'Big Jab' day working with 2 local GP surgeries. All people who were eligible for flu vaccine were invited to local community centre for vaccine where HCC teams in conjunction with other services provided tea/coffee and a 'marketplace' of information stands including falls prevention information.
- Promotion of foot care services
- (Training so that more staff could assess and request walking frames and sticks) Working with home loans to improve the service
- Medication reviews
- Improvements to the environment including footpath repairs, cutting back tree and shrub growth to improve sight on moving traffic, improving grass cutting services, grit/salt deliveries, Handrail installed on steep footpath
- Promoting Home services from an optician for people able to get out and about
- Regular free Tai Chi classes to improve strength and balance

Community involvement in Gateshead contd …

Falls have been reduced by 32% in the three pilot areas based on data collected by ambulance services and local A & E departments. Another key outcome measure of the collaborative was social capital for local residents, measured by a 'social capital questionnaire' developed by the participants themselves. Data showed an increase in social capital during the project. An important outcome is that professionals reported they now understand the patient's perspective. As a result people who fall are now assessed at home so that the professional can see, for example, how someone gets up if they fall during the night.

The steering group is in the process of recruiting a group of senior peer mentors to be trained as Peer Activity Motivators for older people.
The Gateshead team recently recruited new members and began work on widening access to a healthy and affordable diet. This new work is across all age groups except babies and small children. Activities so far include:

- A Men's Group that recently worked on a "Make us a sandwich mate" event promoting healthy sandwich fillings
- "Fit to Feast", a five week course with a gentle exercise session followed by a demonstration on simply prepared healthy foods
- A soup day with demonstrations of how to make hearty soup and distribution of a simple soup cook book
- Local youth club running healthy eating sessions trying different fruits and designing posters and t-shirts to promote fruit
- Setting up fruit & vegetable co-ops and mapping access to healthy foods
- Mapping access problems in shops (eg for buggies, problems with steps)

Contact: Maggie Woodward, Project Manager, Healthy Communities Collaborative
Email: maggie.woodward@ghpct.nhs.uk

Likely outcomes:

Patients/Public
Increased social capital
Improved nutrition
Reduction in falls

NHS
Reduction in admissions from falls

PSA Targets
Reduction in waiting time for admission to hospital

4.2.2 Lay-led self care skills training

Peer-led training in self care for people with long-term conditions has been adopted by the NHS in the Expert Patients Programme (EPP), now being rolled out in all PCTs. The generic course that forms the basis of EPP is to be built upon in several ways including self care skills training programmes for parents, for children and for carers for the care of young and older people with long-term conditions. Apart from EPP, there are other self care skills training programmes, some of which are described here.

- **Skilled for Health**

'Skilled for Health' is a joint initiative of the Department of Health, the Department for Education and Skills and the learning charity Continyou. It aims to promote the concept of health literacy by helping people to improve their basic skills, to link learning to health and to ensure that local programmes, designed to address these links, are implemented. Learning materials are being developed and tested for specific groups with common health issues. Key audiences are teenage parents, people with long-term health conditions, "expert patients", older people and black and minority ethnic health service users. In addition, some of the help will be targeted at NHS staff since it is thought that as many as 100,000 health workers have basic skills problems. For example, it has been estimated that some seven million people in the UK have difficulty reading the label on a medicine bottle. Skills for Health will *"help people to manage practical situations such as making an appointment with a doctor, or calculating a dose of a medicine"* and *"there will also be projects that will help teenage parents to improve their reading skills while they help their own children to learn".*

There are eight pilot sites and their themes are summarised in the chart.

	Theme	Adults	Parents	Older people	BMEs	Mental health
Essex County Council & Harlow Basic Skills project	Basic skills among health workers	√				
Thurrock PCT	Support for parents from Community Mothers basic skills tutors		√			
Camden PCT & Community Local Education Authority	Diabetes among Bangladeshis	√			√	
St Matthews project – Cambridge Training & Development with E Leicester PCT	Health entitlements, self care of health among BMEs	√			√	
Sport Active, Age Concern & Derbyshire PCT	Active Life programme for over 50s	√				
Age Concern Calderdale	Health promotion learning for older people in care			√		
Age Concern Norfolk & Norfolk PCT	Learning group on management of arthritis for older people in rural areas			√		
BE Consultancy & Shropshire County PCT	Teaching materials on health entitlements for people who are mentally ill	√				√

Two of the 'Skilled for Health' pilots with particular relevance to supporting self care are outlined below.

(i) Community Mothers, Thurrock

Parents with young children can access learning provision or support in their own homes from 'Community Mothers' (CMs). The Skilled for Health pilot has built on an existing CM programme running in Thurrock since 1991. The aim of CMs' work is to support and guide parents, to build confidence, increase self-esteem and develop parenting skills. A key factor is that parents as seen as experts in relation to their own child. The Skilled for Health pilot develops parents' basic literacy skills in relation to health thus strengthening self care (for example, reading the labels on medicine bottles, and increasing confidence to ask about things they do not understand when visiting the family doctor, learning about healthy eating and how to read labels on foods). CMs work as peers and equals with parents and clients are referred to them by health workers who have received training in basic skills awareness. Once parents have gained sufficient confidence they can move into Family Learning Courses delivered by Thurrock Adult Community College. The Thurrock programme also demonstrates how capacity for community support is increased. For example Angie Holland is now Community Mother Basic Skills Co-ordinator. She began as a volunteer Breast Feeding Supporter in another long-running programme in Thurrock, went on to become a CM and then a basic skills tutor. The programme is managed by a full-time specialist nurse co-ordinator, Celia Suppiah, Community Development Specialist Nurse.

(ii) Diabetes in the Bangladeshi community project, Camden

The target group is people with diabetes in the Bangladeshi community, many of whom are older people who do not speak English and are a vulnerable, at-risk, group. A course has been developed using the ESOL (English for Speakers of Other Languages) curriculum on diabetes for Bangladeshi adults. The aim is to improve literacy and numeracy skills to help people improve their management of their diabetes. The courses are run jointly by local health professionals and basic skills teachers from Westminster Kingsway College. Trained community link workers (including a local imam) signposted the course and encouraged people to participate. The Camden pilot's aims are: i) help learners gain a better understanding of their own health and how to make better use of the NHS, whilst also improving their basic skills. 2) develop partnership working between health and basic skills practitioners, test new approaches, and heighten awareness of the basic skills needs of NHS users. Phase 2 includes Camden PCT and Community Local Education Authority.

More information about the pilots can be found in the Skilled for Health Update at http://www.dfes.gov.uk/readwriteplus/bank/ACFEE55.pdf

Contact: Caroline Blondell; Email: caroline.blondell@dfes.gsi.gov.uk

- **Disease-specific lay-led self care skills training programmes**

(i) There are established lay-led self care programmes for people with a range of long-term conditions-specific training programmes including Challenging Arthritis and Back Care that have been delivered in the voluntary sector. Within the mental health field the Manic Depression Fellowship provides a course on self care for people with bipolar disorder.

Self care training for people with bipolar disorder

A peer-led self care training programme is offered by the Manic Depression Fellowship (MDF). The aim of the programme is to teach the individual with bipolar disorder how to recognise the triggers for, and warning signs of, an impending episode of illness. Participants learn to take action to prevent or reduce the severity of an episode. Each course is facilitated by two peer tutors who themselves have a diagnosis of bipolar disorder. Support networks and action planning are included. Courses, which comprise six sessions, are running in England and Wales. There is a £12 administration charge to take part and the MDF will pay other reasonable expenses such as travel and accommodation.

Evaluation included both user-led and clinical measures. Significant improvements were found in participants' ratings in several components of Beck's Depression Inventory, including a reduction in suicidal thoughts. The next phase of the evaluation focuses on the impact of the programme on health care costs.

Contact: Michael Grintner, Email: mdf@mdf.org.uk

(ii) Self care for people with obesity and weight problems

Case study: Self Care, Independence, Nutrition & Exercise (SCINE)

Overweight and obese 14-16 year old students participated in a 12-week combined weight management intervention in South East Sheffield. The aim of the programme was, as a minimum, "to maintain the weight of students whilst empowering them to make informed choices that would lead to a healthier lifestyle". Eighteen students took part, nine each in the intervention and control groups. Intended outcomes were that, in addition to weight loss, the students would "learn to self care differently in order to promote a lifestyle that would help them feel fitter, healthier and happier".

The programme was delivered through collaboration between professionals in nutrition, fitness and child/adolescent therapy and had three strands:

- Nutrition intervention – to educate the students in meal planning, grocery shopping and meal preparation, and to enable recognition of the differences between emotional hunger and physical hunger. At the end

of 12 weeks the average weight loss was 0.4 kg per student per week and total weight loss ranged from 3-8 kg.

- Psycho-social intervention – baseline assessments of participating students showed patterns of low self-esteem, high levels of anxiety and depression, and that all students were experiencing some form of bullying related to their weight. Personal development group (PDG) sessions were based on addressing issues of concern to students. By week 12 all participants showed increased levels of self-esteem and decreased anxiety and depression scores.

- Physical activity intervention – this aimed to reduce sedentary lifestyles and increase levels of physical activity, and to make the exercise fun rather than a chore. Students participated in a range of activities including Tai Chi, Kick Boxing and Street Defence classes at the local gym as well as swimming, badminton and gym workouts. At 12 weeks there were significant increases in fitness assessment and peak flow measurements as well as increased confidence to engage in planned activities.

The evaluation of the programme concluded that a tiered approach is needed in the care of children and adolescents with obesity. By addressing psycho-social issues the programme was able to underpin the behavioural changes being made. At 12 weeks the results demonstrated short-term effectiveness and participants were offered a 12 week maintenance programme, which around half took up. Support from the facilitators was gradually tapered down.

Contact: Kath Sharman

Likely outcomes:

Patient/Public
Reduction in obesity
Increased physical activity
Reduced depression / improved mood
Increased knowledge
Improvement in user experience
Increase in social capital

NHS
Reduced service use medium and long term

PSA Targets
Reduction in waiting time for admission to hospital
Increase in life expectancy

4.2.3 Care professional-led self care education and training

Some community-based programmes are led by health professionals and innovative models have been developed to take initiatives out into the community rather than waiting for people to visit the health service.

Healthwise classes in Bradford

Classes are run for community elders in eight community centres (for example the Hindu Temple in Little Horton). The classes include exercise (simple seated and chair supported exercises), cookery demonstrations (healthy curries and reduced fats) and talks on health issues such as healthy eating, osteoporosis, mental health, diabetes and foot care. The classes were set up in conjunction with community organisations. Clients are recruited direct from the community and are also referred by GPs and physiotherapists as part of a local exercise on prescription scheme.

Contact: Shakuntla Sharma, Bradford and District Health Development Service. Shelley Robinson 01274 223923; Judy White 01274 223919 www.bradford-health-promotion.yorks.com/healthwise.html

- A different model is the bringing together of health, social and community resources. In the 'Up for It' programme local people can receive referral for free access to several self care support services.

Case study: 'Up for it?' Programme

The 'Up for it' programme is a health and lifestyle membership scheme that aims to motivate behavioural and lifestyle change. It was set up by the Blantyre/North Hamilton Social Inclusion Partnership (SIP) and funded by the local Health Board, Council and SIP. Disadvantaged and vulnerable residents are referred from a variety of agencies, with an opportunity to participate in a 'Health Club' providing free access to services focused on reducing stress, stopping smoking, reducing weight and increasing exercise. Health checks are provided including CHD risk, stress level indicator and clinical tests. Service providers include public and private sector agencies: South Lanarkshire Leisure, Hamilton LHCC, Royston Stress Centre, Llloyds pharmacies, Scottish Slimmers.

At May 2004 participation included:
- 3,989 health checks and health improvement opportunities
- 281 helped to quit smoking (4 week success rate of 60.2%, 3 month success rate of 26.1%)
- 1,626 have taken up leisure membership
- over 46,100 individual leisure activities undertaken
- 813 have been supported to deal with stress
- 869 have attended weight management classes with over 208 stones lost to date

A children and young people's version of the programme for 3-18 year olds is also running (Junior Up for it?).

Participation at May 2003 was:
- over 3,735 young people aged 3-18 registered
- over 25,587 individual leisure activities undertaken

An 18-month evaluation was conducted by Glasgow Caledonian University and the findings were positive. 'Up For It' has recently been successful in obtaining funding to roll out the programme to other parts of South Lanarkshire.

Contact: Susan McMorrin, Project Manager, Blantyre Health Partnership, 1 Station Road, Blantyre, Glasgow G72 9AA.
Email: susanmcmorrinatupforit@hotmail.com

Likely outcomes:

Patients/Public
Reduction in CHD risk factors
Increased number of smoking quitters
Increased physical activity
Reduced depression/improved mood
Reduction in obesity
Improved ability to cope with stress

NHS
Reduced service use medium and long term

PSA Targets
Reduction in mortality
Increase in life expectancy

- Increasing the capacity of families to understand and respond to long term conditions is key. Some studies have aimed to increase parents' understanding of their children's long-term condition. A Canadian study tested the effects of an education group for parents with depression.

Parent education group for families affected by depression

A Canadian study assessed the feasibility and effectiveness of a parent education group for families with young children and a parent affected by depression (Sanford et al 2003). The aims of the programme were to increase parents' knowledge about depression's effect on the family, to increase positive communication and to enhance parenting strategies. The course comprised 8 weekly sessions of 2 hours. Children were not directly involved in the programme. The results were encouraging and suggest that further testing and evaluation would be valuable.

- Access to advice and medicines out of hours to support self care poses a challenge and creative solutions have been found in some areas.

OOH advice from a multidisciplinary team and OOH medicines supply (Blackpool PCT)

Telephone advice from a multi-disciplinary team comprising doctors, nurses and pharmacists is provided from Fylde Coast Medical Services (FCMS), an urban OOH centre in Blackpool town centre.

FCMS is a well-established focus for the local population for OOH services with some 50,000 patient contacts per year. In addition to OOH medical services the centre includes emergency social services, night nursing, emergency dentistry, mental health crisis team and palliative care equipment. The centre also provides OOH medical support for the local WIC.

Analysis of the prescriptions written for minor ailments at FCMS prior to introduction of the pharmacy service in 2003 showed that 46% were for non-prescription medicines. The scope for completed episodes of care by pharmacists and nurses is considerable. Work has been undertaken to identify which patients categorised 'green' can be streamed to the pharmacist or nurse rather than the GP.

Contact: Suzy Layton, Operations Manager FCMS
Email: Suzy.Layton@exch.bvh-tr.nwest.nhs.uk

4.2.4 Self care peer support networks

The principle of peer mentoring is about engaging people of all ages in activities by listening to 'someone like me'. Peer mentoring is an established tool of health promotion and peer health mentors:

- are someone to talk to 'of my own age'
- point people in the right direction
- help by providing appropriate information
- are someone that individuals can identify with and will talk to
- are someone who will understand things from 'my point of view' and who may have experienced similar problems
- are someone who provides positive health information
- are a positive role model

- The concept of the senior peer health mentor is not new and has been used by Age Concern's Ageing Well programme in the UK and in the US for some years. The Department for Education and Skills (DfES), British Heart Foundation and Age Concern Ageing Well programme collaborated to introduce the **Senior Peer Mentor Physical Activity Motivator Programme**.

Case study: Peer Activity Motivators

A Local Health Survey in Wigan and Leigh found that almost 60% of older people did not take part in any physical activity. Wigan Social Services, together with Wigan Leisure and Culture Trust's Active Living Team and Age Concern, were one of four areas that took part in a national pilot of Senior Peer Mentoring. The mentors, once trained, visit individuals or groups of older people in places like lunch clubs and sheltered housing complexes, with the aim of encouraging residents to participate in a little more physical activity. These activities range from assisted corridor walks, chair-based exercise sessions, health walks and days out. The emphasis is on encouragement, support and fun, recognising that health related messages carry a lot of weight when given by similarly aged people, with similar life and health experiences. The mentors do not lead exercise sessions (although some of them go on to train as exercise leaders) and they do not give medical advice.

A further 16 mentors have been recruited and trained. The new mentors are very enthusiastic about their role in helping to improve both the physical well being and the quality of life enjoyed by the older people they come into contact with.

The encouragement and support provided by the senior peer mentoring scheme is helping to play a part in addressing that statistic.

The scheme is now embedded in the Active Living Team's programme, and will see further expansion next year as part of the Stepping Out scheme, whose local partners include Social Services and Age Concern.

The Senior Peer Mentor handbook has been translated into Urdu, Punjabi and Hindi. Partly based on the success with the SPMs, Wigan is now one of the national pilot sites for Moving More Often, which aims to bring more physical activity opportunities to the frailer older person in residential, nursing home and day care settings.

Contact: Helen Coffey, Older People's Network Co-ordinator

E-mail: h.coffey@wiganmbc.gov.uk

Likely outcomes:

Patients/Public
Increase in physical activity
Reduction in obesity
Reduction in depression/improvement in mood
Increase in skills to train and support others
Increased social capital through involvement of volunteers

NHS
Reduced service use medium and long-term

PSA Targets
Increase in life expectancy

- Weight management is an area where community level support is particularly important. Promoting prevention and treatment of obesity *"should place the individual within his or her community – not within the health care system . . . community resources are critical for helping individuals make healthy choices to manage their weight"* (Raymond 2003).

Case study: Community-led weight management service

A community-led weight management service in West Middlesborough has local residents as group leaders. The scheme was based on evidence and local consensus that a community-led strategy could be more effective than traditional (dietitian/nurse-led) obesity services (Appleton & Summerbell 2003). Two group leaders (both of whom were exercise instructors) recruited from the local community were trained by dietitians to provide peer support to people who wanted to lose weight. The dietitians produced a resource pack for use by the group leaders based on British Heart Foundation materials.

Weekly sessions on nutrition were held in the local community centre and were followed by an optional exercise class held across the road in the sports centre. The programme ran for 20 weeks. Evaluation included detailed follow up of ten women who attended the first programme. Any changes in weight were assessed and feedback was obtained from the group leaders, dieticians and the nutritional support worker (NSW). Nine of the ten service users lost weight. In addition to the outcomes for participants the evaluation assessed the level of ongoing support that the group leaders required and compared the cost-effectiveness of this local resident-run service with services run by other agencies.

The community-led weight management group was perceived by the users, group leaders and trainers to be useful. The cost of the service was 'relatively low'. The evaluation report made a number of recommendations about improvements for the future. Building confidence of group leaders through training and the provision of a selection of resources for use in sessions were identified as being of particular importance. Conducting a needs analysis for group leaders was also recommended.

Middlesbrough PCT plans to roll out the sessions to other areas within the PCT. There may be future opportunities for service users to train to become group leaders.

Contact: Claire Appleton, University of Teesside,
Email: claire.appleton@tees.ac.uk

Appleton C, Summerbell C. Evaluation of the training provided by dietitians to group leaders of a pilot community-led weight management service. University of Teesside, 2003

Likely outcomes:

Patients/Public
Reduction in obesity
Increased physical activity
Reduced depression/improved mood
Increase in self care skills
Increase in skills to train and support others
Increased social capital

NHS
Reduced service use medium and long term

PSA Targets
Increase in life expectancy

- A self care support model for training people with a long-term condition to act as peer support counsellors for that specific condition is being used in Isle of Wight. This approach has been developed and used in diabetes.

Peer support in diabetes

The Isle of Wight has a scheme where people with diabetes have completed intensive training to act as peer support counsellors on all aspects of diabetes. The primary objective of the programme was to impart a high degree of understanding about diabetes. Volunteers were invited to participate through local advertisements and during outpatient consultations and 24 came forward. Training sessions were held weekly for 17 weeks. In addition to providing support to people with diabetes and their carers, the peer support counsellors have played a more active role with local patient associations and have attended open meetings of the Primary Care Trust to help develop local plans. Twelve of the original peer counsellors have volunteered to teach sessions at the next training programme.

Contact: **Dr Arun Baksi: baksi@baksi.demon.co.uk**

4.2.5 Self care support in schools

Case study: 'Bug Investigators' Pack and antibiotic resistance

A science resource to promote a better understanding of infections and create awareness among school-children about antibiotics and their use was distributed to schools in Northern Ireland during 2003. The project was a partnership between the Department of Health, Social Services and Public Safety and the Council for the Curriculum, Examinations and Assessment

(CCEA). The Bug Investigators pack was designed for use by Key Stage 2 Science and PSHE teachers in primary and post-primary schools. It makes use of the cartoon character ***Andybiotic*** who invites everybody to use antibiotics responsibly by explaining which micro-organisms they work on. Andybiotic also gives practical advice on self-treatment for conditions like colds, and most sore throats, that antibiotics do not work on.

The pack contains information, which deals with the problem of resistance to antibiotics and antimicrobial agents and identifies ways to minimise its development. Materials for classes to work on are also downloadable from the internet and include 'What do antibiotics do?' and 'Which illnesses have you had?' and 'To buy or not to buy' (a discussion about whether antibiotics should be sold over the counter in pharmacies).

Parts of the pack can also be downloaded from www.buginvestigators.co.uk including printable projects and a teacher's guide.

Likely outcomes:

Patients/Public -- Increased knowledge; Reduced demand for antibiotics

NHS -- Reduction in consultations; Reduction in use of antibiotics

- Enabling access to health information for adolescents is important to support future self care behaviour. Text messaging of health questions with a response from a community nurse is under test in Cambridgeshire.

Text messaging service for adolescents' health queries

Based on the findings of a survey conducted during a BCG vaccination programme in schools, a text messaging response service for health queries was set up. A community nurse would answer queries within a week of receipt. The service was promoted using key rings, rulers and pencils with the mobile phone number and leaflets. After six months, 147 young people had accessed the service, with 42% of messages related to sexual health, 22% on puberty and 10% on general health concerns. Girls were the biggest users of the service. Prior to the start of the service, the risk officer undertook a risk assessment.

Contact: Mary Gyte, 01763 262861 or Sharon Utting
Email: utting@zoom.co.uk

4.3 The workplace and pre-retirement

'Health and Productivity Management' (HPM) in the workplace is attracting increasing interest. Although 'presenteeism' has previously some negative connotations, the term is now being used to describe an output where employees are more productive and alert in the workplace. Relevant 'return on investment' measures for UK employers include reduced absenteeism, quicker return to work from disability and presenteeism.

A review of workplace health promotion programmes that were comprehensive, multi-factoral and directed at risk management indicated favourable clinical and cost outcomes and outlined the characteristics that contributed to effectiveness (Pelletier 1999). The Health Development Agency includes a Workplace Health section on its website at http://www.hda.nhs.uk/html/improving/workplacehealth.html

The site has invited examples of Good Practice to be featured and these will be added in the future. The European Network for Workplace Health Promotion (ENWHP) and Institute of Health and Productivity Management website feature a series of examples of good practice on their websites: http://www.enwhp.org/home/index.php and http://www.IHPM.org.

NHS Plus

The NHS Plus website currently provides self care advice on a range of minor conditions, many of which are relevant to employment settings (for example irritant and allergic dermatitis). It also runs a series of seasonal health-related topics (eg reducing ski-ing injuries). NHS Plus has further potential in providing decision support for occupational health services.

- There is considerable scope for integrated self care support programmes in the workplace. Such a programme was set up in the US by Pitney Bowes over 10 years ago to address issues of rising health care benefits costs and lost work time.

Case study: Pitney Bowes Health Care University

The Pitney Bowes Corporation in the US set up 'Power of 2' an employer-employee initiative that revolved around shared responsibility between the company and employees. 'Power of 2' was a wide-ranging programme and included a virtual Health Care University (HCU) in 1993. The programme was a response to escalating costs of health care benefits to employees and included a component for integrated care of disability. Although the financial basis for healthcare provision in the US is very different from the UK, this programme has elements of relevance to employers here. The company established an integrated program of screening and early detection, support for appropriate access to health care, self care for individuals, and timely, safe and appropriate return to work.

The strategy has four components: the HCU, on-site access to medical services, care of disease and care of disability. Data regarding participation, outcomes (self-reported and clinical), health and disability claims, and clinic records are captured and utilised in integrated analysis. The HCU was initially aimed at PB's 5,500 Connecticut employees with a range of on-site activities. Early components included comprised a self care programme ('Take Care of Yourself' guide plus educational session),

an on-site Fitness Centre, Ergonomics programme and Care of Disease programme for asthma. The asthma programme was offered through a collaboration with Glaxo Wellcome. Programmes for diabetes and migraine were subsequently introduced. One third of eligible employees participated.

The company used data on medical claims from their health plan, enrolment and disability experience to evaluate the HCU. They found that HCU participants had slower [significantly less] growth in health care costs over time (a decrease of 5% compared with an increase of 2% for non-participants). Self care participants had significantly lower levels of emergency room utilisation.

On-site workplace activities have included:
- cardiovascular and cancer screening
- smoking cessation
- vaccinations
- exercise
- self care and consumerism education
- nutrition counselling
- seminars ('Lunch and Learn' on individual topics plus multi-session courses on for example, weight management, asthma, etc)

Since 1998 the programme has become more 'virtual' to reach employees throughout the US with programmes delivered by mail with telephone counselling (smoking cessation, care of disease, prenatal care, and screening for depression and alcohol problems). The company Intranet was used from 2002 to post health articles and a customised website was launched in 2003 in collaboration with WebMD. The major focus of the site is promoting self care and health education, and enabling employees to be better health consumers.

The company has found that the programme has helped to manage health care costs and has also had a positive impact on productivity measures. The latter has taken three forms: reduced absenteeism, quicker return to work from disability, and 'presenteeism' (improved productivity and alertness at work).

Jan Murnane, Manager for Health and Productivity, Pitney Bowes.
Email: jan.murnane@pb.com

See also
http://healthproject.stanford.edu/koop/pitneybowes/evaluation.html

Likely outcomes:

Patients/Public
Increased knowledge
Increased self care of long-term conditions

NHS
Reduction in health service usage

- Traditionally the promotion of health in the workplace has been seen as an area for large corporate organisations. Some work has been undertaken on encouraging workplace health in small businesses.

Bro Taf Healthy Hearts Small Workplace project

The Health Authority carried out an evaluation of initiatives promoting health in small businesses in the Merthyr Cynon. In the first year a workplace health promotion consultant visited each organisation to assess ongoing provision for supporting health. Employees completed a confidential questionnaire which assessed their current lifestyles.

Employees were then given the opportunity for an individual health screening session where they were given feedback and advice. A follow-up questionnaire was then completed. The results of the evaluation showed that identifying someone who would take ownership of workplace health was a key factor. This might be a small working group of 2-3 employees but in very small business the employer or owner might need to take on this role. Exploring employee opinions, ideas and health needs was also identified as a key step in ensuring resources were well used.

The Health Authority produced a toolkit for employers to review and develop workplace health. The resource provided suggestions for a range of information and activities that employers could select to suit their workforce. It set out the components that were likely to support successful programmes and provided a list of relevant contacts and resources.

http://www.cmo.wales.gov.uk/content/work/workplace/small-workplaces-e.pdf

- **Pre-retirement pilots**

These aimed to inform the development of a national rollout of pre-retirement health advice and services, for those approaching retirement. The initiative is targeted at the midlife age group, 50 to 65 year olds. Leaving paid work is seen as a key transition in the life cycle, when people can be receptive to health improvement messages and early intervention. The programme aims to reduce health inequalities by reaching people who would not readily have access to, or seek out, pre-retirement health advice and preparation. These include, among others, the long-term unemployed, workers in small businesses, urban and rural communities with high indices of poor health, black and ethnic minority populations and people with learning disabilities.

Partnership working is central to its delivery, and the pilots demonstrate a range of complex relationships between public, private and voluntary sectors.

Case study: Peer health advisors in pre-retirement

In its pilot work on pre-retirement the Beth Johnson Foundation, North Staffordshire used a community development approach to engage people in four disadvantaged neighbourhoods. It recruited, trained and supported a group of older people to be lay health advisors to their peers, and to use an audit tool to assess health priorities. Existing community groups, for example, Community Centres and One-Stop Shops were used as recruiting points for the first wave of Lay Health Advisors (LHAs) who would become project champions. A development group involving these first wavers had input to the design of a one day training session that covered the signposting role of LHAs, boundaries and confidentiality issues.

Previous work had focused on identifying the health beliefs of people in the target group for the programme (aged 50-65) and this formed the basis for the health audit tool.

Individual LHAs then held sessions in their neighbourhood. Some publicised the timings and venues of planned sessions while others responded to individual contacts to arrange sessions. These early LHAs then helped to recruit others and support them through their training and initial work. This approach was intended to empower the LHAs and in turn, for them to empower their clients to take control and plan for the future. A typical initial session would last around 30 minutes and act as an awareness raising event that would engage the individual in participating in further sessions. As in the national evaluation (Bowers et al 2003) the pilot found that finances were a key issue for many and that other issues then emerged.

The pilot work identified the importance of making available accessible information to enable people who are in mid-life (50+) to appraise their current situation and make plans for the future. Further work is targeting those individuals who experienced the greatest health inequality and to maintain the community development approach in the 'Planning for the Future' programme. This new initiative was commissioned as part of the local Health Promotion strategy and aims to promote good health and wellbeing into later life. Volunteer advisors receive initial training, ongoing support through networking and the use of a guidance manual that covers process, key procedures and key information. The project also aims to engage with groups of people, initially in the community, and eventually within SMEs, through workshop sessions to raise awareness of the issues, benefits of life appraisal and planning for the future in later life.

Coordinator: Barbara Stoddart, Community Development Worker
Tel: 01782 844036

Email: Barbara@bjf.org.uk

http://www.hda.nhs.uk/downloads/pdfs/preretirement/beth_johnson_v3.pdf

Likely outcomes:

Patients/Public
Increased social capital through involvement of volunteers
Increased understanding of appropriate use of services
Increase in skills to support others

NHS
More appropriate service use

PSA Targets
Improvement in use

Pre-retirement resource pack

The Hull and East Riding area developed a pre-retirement resource pack, designed to promote health and wellbeing. The pack was piloted in a number of health and community settings, involving local people and health professionals in its development and plans for its future delivery. The resource pack covers healthy lifestyles, mental wellbeing, activities, hobbies, leisure pursuits, time and structure, social engagement, voluntary work, isolation, loss and finance.

Coordinator: Sharon Watts, Tel: 01482 617675

Email: sharon.watts@herch-tr.nhs.uk

4.4 Community pharmacies

The potential of community pharmacies to make a greater contribution to self care is widely acknowledged although there are recognised barriers to achieving this. A new NHS contract is currently under negotiation and this will offer opportunities for greater local flexibility in commissioning (DH 2003). 'Choice, Equity and Responsiveness' included a recommendation that PCTs should carefully consider commissioning pharmacy-based minor ailment schemes targeted in disadvantaged areas (DH 2003). Pharmacy-based minor ailment schemes were covered in a previous report (Blenkinsopp 2003).

Case study: Education and advice on children's minor ailments

A collaboration between Sure Start and the four local pharmacies on the Bransholme estate in Hull is making greater use of pharmacies as health advice centres. The aim of the service is to increase parent education on health issues in under-3's in an under-doctored area (East Hull) which is 10 GPs short relative to the national average. Parents register with a local pharmacy and then use that pharmacy for advice on children's minor health problems that they would otherwise have consulted the GP about. The accessibility of pharmacies means that parents can easily seek advice throughout the day and on Saturdays.

The challenge for the scheme is to not simply substitute a consultation with one health professional for another and local GPs were particularly keen that the scheme should educate and empower parents. A series of simple information leaflets has been produced, one for each of the six ailments covered by the scheme: temperature /aches/pains; stuffy nose; colic; nappy rash; diarrhoea/sickness; teething; dry skin.

Pharmacists can supply medicines free of charge on the NHS for five of the six ailments. Experience to date indicates that no medicine is supplied in some 10-15% of cases. In roughly half of these, the pharmacist's view is that advice is sufficient and in the other half, the pharmacist thinks referral for medical advice is necessary.

There has been no formal evaluation of the scheme but informal feedback to Sure Start from parents indicates that the scheme has increased parents' confidence in dealing with minor ailments and in knowing how and when to use local health services. At least a quarter of eligible children are now registered with the scheme.

The scheme, which began in April 2002, has been taken up by other Sure Start teams in the Hull area. It is now to be incorporated into a new, wider, minor ailments scheme for people of all ages. New work is beginning between Sure Start and local pharmacists to develop the public health role of the pharmacy, for example in relation to smoking cessation during pregnancy and in families.

Contact: Angela Nelson, Sure Start,
Email: angela.nelson@hullcc.gov.uk
Mike Rymer, Pharmaceutical Adviser,
Email: Mike.Rymer@EHPCT.NHS.UK

Likely outcomes:

Patients/Public
Improved and more appropriate access to health professionals in primary care

NHS
Reduction in GP consultations
Increased use of pharmacists

- An increasing number of areas are introducing community pharmacy-based weight management services as part of local strategies to tackle obesity. Northern Ireland's Community Development Programme included a pharmacy-based weight management service.

The Healthy Weight Challenge

An independent community pharmacy in Belfast set up the 'Healthy Weight Challenge' in partnership with the Falls Road Women's Centre. The pharmacist worked closely with women from the group to design a service that would encourage women to participate and not over-medicalise the problem of weight management. It was agreed that use of the words 'fat' and 'obese' was demotivating and the concept of 'healthy weight' was used instead. The service was advertised by posters, leaflets and a local newspaper and 38 people registered for the service. Participants met with the pharmacist in the consultation area of the pharmacy for a private discussion about diet and exercise. Evaluation was conducted by follow-up interviews with ten participants at four weeks. Ages ranged from 21-67 years and at follow-up eight of the ten had lost weight and the others had stayed at their original weight.

The pharmacist learned from service users that the causes of excess weight were complex and often socially-based. Interventions involved lifestyle, social and health elements.

Contact: Terry Maguire, Email: Terry.Maguire@dhsspsni.gov.uk

4.5 Walk-in Centres (WiCs) and minor injuries units

Walk-in Centres and walk-in facilities in GP practices and health centres provide advice and treatment for a range of clinical conditions as well as advice to prevent ill-health. They are an important component of patient choice in primary care and their scope was recently defined:

Scope of Walk-In Centres
(Department of Health 2003: Ambulatory Care Plus)

Minor ailments
Lacerations
Cuts & bruises
Sore throat
Hay fever
Migraine
Splinting
Acute mental health
Emergency contraception
Early pregnancy assessment
Health promotion and prevention advice

The national evaluation of WiCs showed users to be highly satisfied with the service and that the main reason for using it was that it would be quicker than getting a GP appointment. The most commonly-presenting complaint was respiratory infections ('flu and the common cold) followed by unprotected sexual intercourse. Compared with attenders at a general practice those at a WIC were more likely to be given advice or information and less likely to receive a prescription.

Minor Injuries services (of which there were 306 at the time of the last UK survey) are another source of advice which may include self care. Around one third described themselves as minor injury and minor illness services (Cooke et al 2001).

4.6 Self care support in General Practice in Primary Care

Many general practices now provide minor illness clinics, often nurse-led and discussed in detail in a previous report (Blenkinsopp 2003). Support for self care is provided in a number of ways including provision of information on practice web sites. Some practices have introduced innovative schemes to increase physical activity as part of local community programmes.

Case study: The Green Gym and Health Walks

Sonning Common Health Centre developed two community-based programmes aimed at offering different ways for people to increase physical activity.

The Green Gym is a unique project run by the British Trust for Conservation volunteers (BTCV) and Sonning Common Health Centre. Its aim is to:

"Promote fitness, well-being and health for everyone through physical work by improving the local environment"

The Green Gym promotes health and fitness through involvement in nature conservation. To date it has involved approximately forty local people and has made significant environmental improvements, including helping to plant 500 trees on a local site. Other activities include creating school nature areas, hedge-laying and learning rural crafts such as constructing dry stone walls. The group meets and works two mornings a week.

Since the original Sonning Common Green Gym others have been started in Portslade (near Brighton), Kirklees (Yorkshire), Bristol and Northern Ireland.Oxford Brookes University has published a research paper on the health benefits of the Green Gym and, in short, working on the Green Gym uses up more activity than skip aerobics - and you have benefited the environment as well.

http://www.greengym.org.uk/

Health Walks

The Health Walks project was set up by one of the Sonning Common GPs with a local fitness instructor to encourage people to improve fitness by using the local countryside for walking. The programme started from an idea of one of the practice GPs, who produced maps for local walks and offered them to patients. Initially the project had a slow start and focus groups of patients were used to explore the barriers to participating. The main obstacles were: women feeling vulnerable when walking alone, getting lost, lack of motivation and older people finding stiles difficult to climb. In response to this feedback, a range of graded walks was introduced with a timetable and tested over a period of several months. People were referred to the scheme from heart disease, diabetes and hypertension clinics but most self-referred after reading or hearing about the scheme.

Over 400 walks have been organised in each of the 5 years the programme has been running and over 800 local people have taken part (Bird and Adams 2001).

The walks cater for people of all ages and fitness levels and are graded into A (faster), B and C (slower walkers). Walks are also graded as Green (flat with no stiles); blue and red (generally have stiles and hills). Walks are led by local volunteers. The walks are now independent of the health centre and this has increased the social aspects.

http://www.healthwalks.freeserve.co.uk/

Likely outcomes:

Patients/Public
Reduction in obesity
Increase in physical activity
Reduced depression/improved mood
Increased social capital

NHS
Reduced service use in the medium to long term

PSA Targets
Increase in life expectancy

Population approach to self care in heart disease prevention

When ischaemic heart disease was identified as a priority in a practice-based health needs assessment a number of self care activities resulted. A series of recipe cards for low-fat, low-cost, easy to prepare meals was produced and they were made available at the surgery. The primary care team organised a health fair for local people providing information and 'taster sessions' on diet, stress, smoking and exercise.

Contact: to be updated
Email: to be updated

- General practices have also experimented with different models of information provision, including free internet access. Research is highlighting how such resources are used, potential barriers to their use and how these issues might be addressed.

Provision of internet access in general practice

A free, guided internet service was set up in an inner-city general practice serving a relatively disadvantaged population and usage by the public was poor. To explore the reasons why, similar access was provided in a suburban practice serving a relatively affluent population. Patients were surveyed in both practices. Use of the Internet was found to be predicted by a series of factors and there were, in order of decreasing relative importance: 'positive outcome expectancy' (the patient's strength of belief that using the internet would enable them to deal better with their health); previous use of health websites; positive 'self-efficacy' (patients' confidence in their ability to use the technology); higher education; a positive attitude to getting health information from alternative sources); social deprivation; and having school age children living at home. Level of internet access was an important determinant of self-efficacy, but home access was the key predictor of outcome expectancy and past use of 'e-health'.

The authors concluded that *"Proposals to encourage widespread use of digital health information need to take account of the complexity of access, demographics and motivational factors".* They note that their research indicates that motivational factors are of particular importance (Mead et al 2003).

4.7 Emergency care

4.7.1 Accident and Emergency

"*I don't believe in this concept of inappropriate attendances. If someone turns up wanting help, you give it to them but, if we can channel things differently, then people might get even better help, quicker help, more convenient help, somewhere else*." Professor George Alberti, Dec 2003

Key points:

- Service users accessing A & E for minor injuries and minor illness regard that consultation as a crisis point. They are preoccupied with obtaining a solution to the immediate problem and those providing the service report limited opportunity for education about future service use.
- Further work is needed to develop effective methods of building service users' knowledge, skills and confidence to use other services and to use self care where appropriate.
- Local action on creating and promoting emergency care networks has the potential in this respect.

Minor illness and minor injuries are commonly presented at A & E departments and account for around half of attendances (Coleman et al

2001). Some studies indicate this figure to be higher. Considerable work has been undertaken to streamline the care of minor ailments in A&E and to reduce the time taken to deal with them. Innovative practice has been spread through the Emergency Care Collaborative and many A & E departments have implemented service developments in this respect (Cooke et al 2002).

Attention is increasingly turning to the reasons why A & E is used for minor illness consultations and to possible interventions to reduce usage of A & E through increased self care. In a large survey of attenders, key reasons for A & E use include:

- lack of knowledge about other services (16%)
- lack of knowledge about when other services were open (23%)
- having to wait for a GP appointment (27%)
- wanting to see a doctor as soon as possible (27%)
- seeking reassurance that the problem was not serious (33%)
- belief that an X-ray was needed (48%).

The findings of the study indicate that at least 7% of people attending A & E for non-urgent problems might be expected to present to providers other than A & E in the future and that an estimated 13% might have been directed to self care by NHS Direct. However the complex interplay between clinical need and service users' own perceptions and beliefs plays a key role in determining which choice is selected (Coleman et al 2001).

A & E as a setting for education about self care

Given the research findings on why people decide to attend A & E it follows that efforts to educate service users and to promote self care in the A & E setting itself might be useful but would require effort at bringing practitioners on board. Several approaches have been tested in the A & E setting:

- Computer-based information in A & E waiting room
- Joint triage nurse and patient use of NHS Direct Online algorithms
- Provision of written information on follow-up self care for minor injuries.

Providing access to information on minor illness in A&E

The use of an NHS Direct Information Point was trialled in A & E at Norfolk and Norwich University Hospital in 2000 for 6 months. The information point was installed in the A & E waiting room and staff encouraged service users with minor ailments to use it. From their overall experience, the A&E staff felt that more preparatory and awareness raising work needed to be done at the outset to make the approach acceptable to patients.

Use of NHS Direct Online by triage nurses

The NHS Direct Online version of "Not Feeling Well" was used by triage nurses at Norfolk and Norwich University Hospital. The nurse used the algorithms to demonstrate the system to the patient. If the algorithm

recommended self care the patient could then choose whether they accepted that recommendation or whether they waited to be seen. Where the recommendation was self care around 50% of patients accepted it and the other 50% decided they would wait to be seen anyway. Feedback from triage nurses showed that they found this approach too time-consuming. They felt the formal system did not take account of their clinical experience. Again, awareness raising work would need to be done for both patients and the practitioners.

These examples illustrate two key issues. The first is the nurses' own perceptions about the value of the decision support system. The second is the acceptability of such systems for service users. Research indicates that while obtaining reassurance is an important motivator for attending A & E, seeing a doctor may also be important.

- One area where action in A & E has been found to affect future behaviour is the provision of information about follow-up self care for specific conditions. A Canadian survey of 41 accident and emergency departments found that 29 provided an advice sheet, leaflet or booklet but that few were evidence-based.

Written information on follow-up self care for minor injuries

The use of good quality written information at discharge, for example, leaflets for whiplash, knee and ankle injuries, is important in promoting self care. There is evidence that good quality information on discharge from A & E reduces long-term morbidity and increases user confidence and is as effective as face to face instruction (Mike Lambert, A&E Consultant).

An evidence-based patient educational booklet for whiplash associated disorder with extensive end user evaluation was recently developed and tested in the UK and was found to have a significant effect on patients' beliefs (McClune et al 2003).

This example suggests there is potential to develop user-tested educational booklets to support self care following discharge from A & E. Overall the feedback from those providing A & E services was that opportunities to promote self care more widely were limited by service users' preoccupation with resolving the current episode. Attenders and A & E, like users of out of hours services, were seen to perceive the episode as a crisis and to be unresponsive to attempts to introduce education about future health behaviour.

Promoting self care prior to A & E attendance

"What happens in A&E is heavily influenced by what happens outside A&E, and that's why good emergency care networks are so important". Rosie Winterton, Minister for Health, Dec 2003

There are several settings in which self care could be promoted with the potential to reduce A & E attendances. Patients needing care for relatively minor injuries or illness already have choices including self care, pharmacies Walk-In Centres and NHS Direct but may need more decision support. The group looking at emergency care as part of the recent 'Choice, Responsiveness and Equity' consultation concluded that while some patients were comfortable with this degree of choice many others found it confusing or simply did not know about all of the available services.

Referral points to A & E include self-referral (accounting for around three quarters of presentations through direct attendance or via the ambulance service); employers and occupational health services and schools.

4.7.2 Ambulance services

There are two points where decisions are made: during the initial telephone call and when the ambulance crew arrive at the scene. An estimated 25-30% of 999 calls do not result in the patient being taken to hospital (Mike Lambert, A&E Consultant, personal communication).

- In one study of emergency calls, up to 40% could have been dealt with by primary care, psychiatric services or social services (Victor et al 1999). An analysis of 'non-serious' 999 calls indicated that telephone assessment of category C calls identifies patients who are less likely to require emergency department care and that this could have a significant impact on emergency ambulance dispatch rates" (Dale et al 2003). Nurses were more likely than paramedics to assess calls as requiring an alternative response and the reasons for this are not clear.

Case study: Pilot study with non-serious 999 calls

Greater Manchester Ambulance Service NHS Trust (GMAS) is a high volume call service and dealt with almost 300,000 calls in 2001-2. GMAS and NHS Direct Greater Manchester, Cheshire and Wirral established a working partnership and conducted a pilot study in which NHS Direct nurses were introduced into ambulance control with integration of CAD and CAS systems.

Low priority 999 calls from a predetermined list of AMPDS calls were passed to NHS Direct nurses for further assessment. Calls could be returned for an urgent 'transport only' option. During the pilot 1261 calls were passed to NHS Direct, an average of 16 (0.02%) per day. Of these 1261 calls 38% required no ambulance and 62% were returned to the ambulance service. Overall 23% required a 999 response, with 16% needing immediate A & E care and the remaining 60% a less urgent disposition. Thus a substantial proportion of calls were returned for an ambulance response for 'transport only' or 'other assistance'.

Thirty-nine condition codes have been passed for NHS Direct nurse advice. The most frequently used codes were 'sick unknown', 'falls with peripheral injuries' and 'abdominal pain'. In total 477 emergency responses were saved (6 per day). A two-year randomised controlled trial is now underway

to evaluate the safety, appropriateness and effectiveness of care of non-serious 999 callers. The study involves three ambulance and corresponding NHS Direct sites (Wales, Manchester and Thames Valley).

Contact: Janette Turner, Medical Care Research Unit, University of Sheffield

Likely outcomes:

Patients/Public
Reduction in unnecessary hospital attendance

NHS
More appropriate and efficient use of ambulances

PSA Targets
Reduction in waiting time for admission to hospital

A two-year study to evaluate the care of non-serious 999 callers with either self care or referral to alternative healthcare following nurse-led telephone triage has been funded by the Department of Health Service Delivery and Organisation programme (Snooks et al 2003).

Research has also investigated advice given and actions taken by ambulance crews. An analysis was conducted of 500 consecutive cases where the ambulance crew decided not to transport the patient to hospital after an emergency 999 call and the largest category was falls, at 34% (Marks et al 2002). There may be further scope to increase the amount of self care advice given by ambulance service staff by ensuring robust mechanisms for formal training, risk assessment and decision support that give staff confidence to advise self care rather than transport the patient to hospital (Judge TP 2004; Lambert M, personal communication).

4.7.3 Emergency care networks

"It's vital that emergency care networks get going soon wherever they aren't already functioning. There are already good examples, like Manchester where the ambulance trust takes the leading role.

And networks could help to release a lot of unused potential. Consider the part that pharmacists already play in providing unscheduled health care and advice. A study at St Thomas's showed that 8% of A&E patients could have got appropriate care from a pharmacist, another good reason for getting good networks up and running.

NHS Direct, ambulance trusts, urgent care centres, A&E, pharmacists and out-of-hours providers co-operating with patients to deliver the care that the patient actually needs". Rosie Winterton, 2003

Effect of over the counter availability of emergency contraception on attendance at accident and emergency departments

Emergency hormonal contraception (EHC) became available over the counter from pharmacies in 2001 for women aged 16 and over. Local pharmacies provide an additional access point for EHC. This change was welcomed by emergency physicians and there were anecdotal reports of fewer requests for EHC at accident and emergency departments. A study was therefore undertaken to see whether these anecdotal reports were accurate. A review of patient records from two emergency departments in the South East Thames region showed a 52% reduction in the number of women attending for EHC between 2000 and 2001 (Kerins et al 2004).

This example shows the effect of a change in one part of the system on attendance at A & E and suggests there is further potential to identify other work which could be transferred. Local health economies can take action to promote the local emergency care network.

Matching systems to patients' needs

a. Determining what services are available locally
b. Developing/adapting services to meet patient needs
c. Re-routing patients to the most appropriate services (eg introducing protocols to enable A & E triage nurse to re-route patients to other appropriate services such as high street pharmacist, dental, primary or self care).

Source: Improving the flow of emergency admissions

4.8 Intermediate Care

Partnership working between health and social care is leading to innovative models to promote independent living and prevent unnecessary hospital admissions. In 'Step Down' care people have a stay in a rehabilitation unit to relearn essential self care skills and prepare to resume independent living at home. In 'Step Up' care people are admitted to intermediate care following referral and concern that a hospital admission might be imminent.

Case Study: East Devon Intermediate Care Co-ordination Centre

This support for self care in the Intermediate Care setting aims to promote independence in order to allow people to take care of themselves in their own homes and facilitate early discharge from and prevent unnecessary admission to hospital. The East Devon centre went live across the PCT in June 2004 following a successful pilot and handles all referrals for rapid response, recuperative care and supported discharge.

The service offers short-term (up to 6 weeks) goal-oriented and multidisciplinary rehabilitation and the average length of service is 4.3 days. That can be in the person's home or in a residential setting. Intermediate Care

Support Workers are at the heart of the service and are recruited either with an NVQ in health or social care, or with extensive experience in a care setting. Staff who do not already have Level 3 NVQ relevant to post are required to start one within six months of beginning the job. **'Rapid Response'** is provided in the client's home, typically for 7-10 days. Examples include falls that did not result in serious injury but where temporarily limited mobility means that additional support is needed. The measures put in place might include meals on wheels, a night sitter and emergency necklace alarms.

Support workers provide a **'Re-ablement Service'** for rehabilitation in any setting and where appropriate they implement therapy plans in the client's own home. These plans are designed by the Occupational Therapist or Physiotherapist. In **'Recuperative Care'** simple goal-oriented rehabilitation is provided in a residential setting for clients for whom the aim is to return to their own home always with a date for return home.

The criteria for roll out following the pilot were evidence of avoided admissions and of achieving earlier discharge. The service has 6 referral co-ordinators and 2 joint managers. Between April and October 2004 evaluation showed that 162 admissions were avoided (52 acute hospital and 110 community hospital). Only 7% of cases managed through the Centre were referred on to Social Services for long term care. Feedback from local GPs is positive.

Likely outcomes:

Patient/Public
Increased confidence
Maintained independence

NHS
Reduction in admissions from falls
Maximise capacity of acute hospital beds

PSA Targets
Reduction in waiting time for admission to hospital

Contact: Val Gilbey Joint Lead Manager, Intermediate Care Services Co-ordination Centre; Email: val.gilbey@eastdevon-pct.nhs.uk

Case study: 'Homeward Bound' Units in Cornwall

The 'Homeward Bound' scheme is led by Social Services in partnership with local PCTs. Five 'Homeward Bound units (HBUs) in Cornwall were set up to support people who have been identified as needing intensive support and therapy before returning to independent living. The units provide an opportunity to practice, regain and maintain the skills that they consider important in improving their independence, such as dressing and eating. Staff trained as Rehabilitation Care Assistants work with therapists to provide the service.

Monitoring showed that 72% of admissions were from hospital (most of these from acute trusts) in order to facilitate discharge and this 'step down' aspect of

the scheme was contributing to maximising capacity in acute beds. The average length of stay in a HBU ranged from 28-35 days and over three-quarters of people discharged from HBUs went home, and 40% of these required no package of care. The remainder went into hospital or into a care home.

The 'step up' aspect of the scheme was initially little used and accounted for only a small proportion of admissions.
Feedback from patients showed very high levels of satisfaction with the services provided at Homeward Bound Units (Asthana 2002). A cost benefit analysis indicated that residential rehabilitation in HBUs was more cost-effective. The evaluators also commented that *"the value (of HBUs) may rest more on factors such as quality and appropriateness than in cost-effectiveness"* .

Contact: Sheena Asthana, Email: sasthana@plymouth.ac.uk

Likely outcomes:

Patients/Public
Maintained independence

NHS
Reduction in readmissions

PSA Targets
Reduction in waiting time for admission to hospital
Improvement in user experience

- Many people in intermediate care are taking several prescribed medicines. Difficulties with medicines can be a reason for admission to hospital or for 'step up' to intermediate care. Identifying and resolving medication-related problems is thus an important pre-requisite for returning home.

Self-medication training in Berwood Court

Self-medication of prescribed medicines is an important contributor to maintaining independence and enabling people to live at home. Berwood Court Intermediate Care Unit in Birmingham has developed a self-medication scheme to enable clients to increase their knowledge and improve control of their medication. The scheme has a protocol that includes a structured assessment for self-medication based on a checklist; patient counselling procedure covering the reason each medicine has been prescribed, how and when to take it.

Contact: Alima Batchelor
Email: alima.batchelor@EasternBirminghamPCT.nhs.uk

4.9 Podiatry

Podiatry services have tested innovative approaches to encourage self care of foot problems where appropriate within a risk management framework.

Case study: Self care programme on basic foot care for older people (FOOTSTEP)

A self care programme was developed as a part of a scheme involving training for patients, carers and volunteers and the issuing of foot care packs containing basic items for foot self care. The stimulus for the scheme was the need to manage demand from older people for routine, non-urgent podiatry care. The clinical and cost-effectiveness of the programme were evaluated through a randomised controlled trial with 155 patients.

Patients were screened using a protocol to identify those requiring only basic foot health treatment for problems of minor severity and 39% were in this category, and around one third agreed to participate in the study. Exclusion criteria for the study were based on joint guidelines by Age Concern and the Society of Chiropodists and Podiatrists. A physical assessment was undertaken to determine each person's capacity for self care of the foot. Self care assistants (volunteers from Age Concern, friends and family members) provided support and received the same tuition in self care as the participants. Training sessions for patients, carers and volunteers were run as small workshops and lasted around an hour. Foot care packs were distributed to individuals to take home and keep after a demonstration and hands-on practical session in the workshop.

The results of the trial showed that patients who participated reported less foot disability and required fewer podiatry sessions. A limited cost-benefit analysis indicated that the approach was cost-effective (Waxman et al 2003).

After the trial and in response to client request Calderdale Podiatry continued to work with Age Concern (Calderdale) and trained additional volunteers to provide a nail care service in the day care centres for their clients. Calderdale and Huddersfield (now a merged Trust) are preparing a report for the commissioners to seek approval and backing for the integration of the FOOTSTEP project into the podiatry service. Some training for staff to support implementation may be available to Trusts who are interested in introducing this project.

Contact: Helen Woodburn, Rheumatology & rehabilitation research unit, Leeds University. Email: Helen.Woodburn@cht.nhs.uk

Likely outcomes:

Patients/Public
Increased knowledge
Increased capacity to self care for foot health
Increase in skills to support others
Increased social capital through involvement of volunteers

NHS
Reduced demand for non-urgent chiropody appointments

4.10 Hospital outpatients

- Group education sessions are one model which has been developed to support self care.

Case study: North Bedfordshire Diabetes Centre

Empowerment of patients with diabetes is part of the fundamental aims of modern diabetes care. The care given to patients attending the North Bedfordshire Diabetes Centre is designed to promote patient choice and enable those with diabetes to make informed decisions about how they manage their diabetes. The clinic program includes an equal number of visits to diabetes specialist nurses and doctors with the aim of the nurse clinics being educational review, updates and goal setting .

There is a handheld patient record with clinical and educational information which contains spaces for agreed individual goals for each patient. After diagnosis patients with Type 1 diabetes are offered a structured program of education with the aim of equipping them with the skills necessary to manage their diabetes effectively in daily life. Patients with Type 2 diabetes are offered group sessions with members of the multidisciplinary team both after diagnosis and later on. The Centre team will start running the DANFE (Dose Adjustment for Normal Eating) programme for patients with Type 1 diabetes in January 2005.

Contact: Dr Nick Morrish
Email: nick.morrish@bedhos.anglox.nhs.uk

Likely outcomes:

Patients/Public:
Increased knowledge
Increased confidence
Increased active self care by people with diabetes

NHS:
More effective use of consultations
Reduced service use in the medium-long term
Increase in life expectancy

PSA Targets:
Improvement in user experience

Case study: Falls Education Programme

An Elderly Health Unit is the focus for a falls education programme offered to people attending the Day Hospital at Liverpool's Broadgreen Hospital. After medical reasons for falls had been excluded, individual physiotherapy was offered. An original idea of offering classes in Tai Chi developed into an 8-week course that also includes sessions from community resources

including Age Concern and local Leisure Services. The instructor is himself 69 years old, providing a peer element. In total 94 people have completed the programme, all of whom had previously had a fall, and 3-month follow up showed a 16% reduction in a score of Fear of Falling and a 10% increase (5.3 points) in the Berg Balance score.
Although participants are encouraged to continue Tai Chi when the course finished, follow-up showed that only half did so. A telephone survey showed that the main reason for this was problems with transport, particularly difficulties with bus travel. People reported a lack of confidence in using public transport because of a perceived risk of further falls. In response staff opened discussions with the local Active Ageing Centre (run by Age Concern) and Leisure Services. The resulting idea of satellite sessions run by Leisure Services trainers (for example, chair-based exercises in local lunch clubs and other community venues) was developed as a result.

Contact: Chris Drake, Email: chris.drake@rlbuht.nhs.uk

Likely outcomes:

Patients/Public: Increased confidence; Fewer falls; Increase in skills to support others; Maintained independence

NHS: Reduction in admissions due to falls

PSA Targets: Reduction in waiting time for admission to hospital

- Outpatient visits have also been used for groups of patients have also been used for self care support.

'Cluster visits' for diabetes care

Patients with poor diabetes control participated in outpatient 'Cluster visits' in groups of 10-18 in the US (Sadur et al 1999). Six sessions were held at monthly intervals involving a diabetes nurse educator, a psychologist, a nutritionist and a pharmacist. Patients in the intervention group had a significant improvement in diabetic control, and significant increases in self care behaviours and self-efficacy. Patient satisfaction with the programme was high and use of hospital and outpatient resources were significantly lower in the intervention group.

4.11 Hospital Day Cases

Patients who attend hospital for day case surgery may be otherwise well and need to be informed about the procedure itself, preparing for the operation and monitoring their own recovery afterwards. Good written information can help patients to identify when recovery is progressing as expected and also signs that need to be assessed by a health professional.

My Health Calendar

Day surgery patients receive a calendar-style booklet with room for notes starting from the day before surgery. The booklet goes on to explain what will happen on the day of surgery including in the operating room, the recovery room and the on return to the day surgery unit. Information is then provided about what to expect on the first and second days after returning home including recommendations about pain relief, the use of analgesics and the expected time for post-surgical pain to wear off. Guidance is given on when to call day surgery or go to the emergency room if specific symptoms occur.

A section on Practical Advice covers driving, medication, wound care, bathing and showering. The booklet was developed by the University of Moncton, Canada and is available at:

http://www.cna-nurses.ca/pages/whats_new/self_care/supporting_selfcare_book.htm

4.12 Hospital Inpatients

Provision of good quality information to patients who are due to have surgery can prepare patients to be engaged in recovery post-operation. User input to such information can ensure that what is important to patients is included.

Case study: Pre-Operative Patient Education project, Australia

Pre-operative patient education is an important part of the Geelong Hospital's Perioperative service and offers a challenge because many patients do not attend the hospital before admission. A series of brochures was developed for different operations. Focus groups were then held with three groups of patients who had major surgery (hysterectomy), and less complex surgery (inguinal repairs and Carpal Tunnel repairs) to assess whether the information had met their needs.

Patients wanted more information about the causes of their health problem, current methods of treatment, the period immediately after their operation, activity after they had returned home, and use of medicines to relieve pain.

Key findings included the need to give better explanations about terms that professional staff thought straightforward (for example, 'light household activities') and that while some of the surgery might have been considered minor, its effects on patients' lives had not been minor. All existing brochures were then reviewed and revised, with further feedback obtained from patients. Information is aimed at reading level of Grade 6 to Grade 8. The next phase of the work was to improve patient access to information by developing an interactive web page that patients could use in the hospital

and at home, and that surgeons and GPs could use to support their consultations.

The hospital has an ongoing programme of user input and feedback on these materials.

http://www.gh.vic.gov.au/periop/
specific surgery information: http://www.gh.vic.gov.au/periop/specinfo.htm

Likely outcomes:

Patients/Public
Increased awareness of significance of post-operative changes
Increase in skills to support others

NHS
Reduced delay in consultation about post-operative complications

PSA Targets
Reduction in waiting time for outpatient appointment

- Using some of the time during the inpatient stay to prepare patients for managing their condition at home is well recognised as a potentially helpful intervention. Recent evidence suggests that even a short educational intervention but one that is targeted to the individual patient's issues and concerns can have an effect on future health and readmission rates.

Case study: Pre-discharge education in heart failure

Individualised education before heart failure patients leave hospital has been shown in a recent trial to have important effects on subsequent self care at home and to reduce the risk of readmission by one third. The trial compared one hour's one-to-one education with the pre-discharge brochure that the hospital usually used. Previous research indicated that nurse-led education could increase patients' self care behaviour but the intervention was longer and more intensive (Jaarsma at el 1999).

In the new study the one-hour long education sessions were delivered by a specialist nurse and included what lifestyle changes and habits can improve a heart failure patient's future health prospects and why, as well as what drugs are used to treat heart failure, why there are so many, how they work, what their benefit is and what side effects they can cause.

Patients who received the education scored more highly on self care measures including:
- following recommended salt and fluid intake restrictions to prevent water retention
- recording daily weight to monitor fluctuations and spot fluid retention
- doing exercise
- monitoring changes in symptoms and making an action plan for what to do if symptoms worsened.

The researchers commented *"we targeted patients during their most 'teachable moment', when they're inpatients and confronting the significance of their illness"*. Another key feature was that the consultation was patient-centred using a concordant approach, *"giving them time to ask questions and helping them to think through their personal experiences . . to link what we know are common heart failure symptoms to their own experiences . ."*.

The lead nurse contrasted this approach with previous interventions that were pre-defined and where patients received 'instruction' rather than having a dialogue. She commented that *"assessing and highlighting their own symptoms . . and explaining simply why those symptoms occur . . . helping them with concrete plans for managing dietary and fluid restrictions . . helps the patient to understand the disease as a whole, and be more vigilant for future exacerbations"*.

The researchers' view is that *"this education is well within the realm of the bedside nurse"* providing sufficient time were available.

Discharge education improves clinical outcomes and adherence to self care measures in patients with chronic heart failure. American Heart Association Scientific Sessions 2003 Abstract Oral Session 2219.

Contact: Monica Johnson, Clinical Research Co-ordinator, Heart Failure and Transplant Management Program, University of Michigan Medical Centre, Email: monicalj@umich.edu

Likely outcomes:

Patients/Public
Increased understanding of the need for self care activities
Increased active self care

NHS
Reduction in delays in instituting measures to prevent exacerbations
Reduction in admissions due to exacerbations

PSA Targets
Reduction in mortality

- The inpatient stay is also an opportunity to encourage patients to start to participate in physical activity.

Exercise for older people: Older people in 2 local hospitals are doing chair-based exercises as part of Age Concern pilot project in Burntwood, Staffordshire; Contact: Age Concern 020 8765 7200

4.13 Residential and nursing homes

Residential and nursing homes have roles in self care in improving health and preventing further ill-health for residents, and also in preparing people to return to independent living at home through 'step up' and 'step down' residential periods as part of intermediate care. Care homes are a potential setting to introduce physical activity to improve strength and balance and reduce the likelihood of falls.

Case study: Moving More Often

The 'Moving More Often' programme is designed to increase physical activity and aimed at all older people in care settings, and of all abilities and needs. Settings include residential and nursing homes, and sheltered housing. The programme began in April 2003 and aims to:

- Provide enjoyable, purposeful physical activity and learning for older people
- Raise the profile of physical activity among older people
- Improve training opportunities for health and care workers & volunteers
- Assist managers in services to support their staff
- Support the implementation of health and care policies for older people
- Create a learning network for related professionals, activity leaders and organisations
- Partnerships have been formed between physical activity co-ordinators and local care settings in a set of pilot sites.

There are four themes within the programme:

- *"The Games People Play" (a* variety of appropriately designed collaborative and competitive games)
- *"Walk With Me" (*Promoting opportunities for independent and assisted walking)
- *"Out and about" (*Making the most of opportunities for physical activity in the local community)
- *"Just Me!" (*Opportunities to be active on my own)

Each local setting involved in the training programme was provided with a "Red Bag" resource containing activity, play and games equipment and activity cards for leaders, wall charts and a handbook. In the first year the programme aims to reach 30 care settings, 60 activity leaders and 360 older people. Pilot areas include Wigan and Kirklees.

Contacts: Juliet Jackson, Kirklees pilot,
Email: Juliet.jackson@kirkleesmc.gov.uk

Bob Laventure, Consultant, Older People, British Heart Foundation
National Centre for Physical Activity and Health, Loughborough University.
Tel 024 76741143, Email: bob.laventure@ntlworld.com

Likely outcomes:

Patients/Public:
Increased confidence; Reduced falls; Increased physical activity

NHS:
Reduction in hospital admissions due to falls

PSA Targets:
Increase in life expectancy

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Project and Editorial team:

Alison Blenkinsopp, Professor of the Practice of Pharmacy, Keele University
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References:

Asthana S, Halliday J, Bennett G (2002). Cornwall and Isles of Scilly HAZ Programme Level Evaluation Report: Children and Young People's Programme and Eldercare
http://www.haznet.org.uk/hazs/hazmap/cios_eval-summative-apr02.pdf

Bird W, Adams F. Sonning Common Health Walks: A Four Year Review (2001). www.transport.wa.gov.au/conferences/ walking/pdfs/B6.pdf

Blenkinsopp A (2003) Minor illness management and self care: a scoping study to describe the range of service models. Keele University.

Bowers H, Secker J, Lanes M, Webb D. Health Development Agency (2003) The Gap Years – Rediscovering mid-life as a route to healthy active-ageing. http://www.hda-online.org.uk/documents/gap_years.pdf (accessed 16/3/04).

Coleman P, Irons R, Nicholl J. Will alternative immediate care services reduce demands for non-urgent treatment at accident and emergency? Emerg Med J 2001; 18: 482-487.

Cooke MW, Higgins J, Bridge P (2001). Minor Injury Services: The present state. Emergency Medicine Research Group, Universities of Warwick and Birmingham.

Cooke M, Wilson S, Pearson S. The effect of a separate stream for minor injuries on accident and emergency department waiting times. Emerg Med J 2002; 19: 28-30.

Dale J, Higgins J, Williams S, Foster T, Snooks H, Crouch R, Hartley-Sharpe C, Glucksman E, Hooper R, George S. Computer assisted assessment and advice for 'non-serious' 999 ambulance service callers: the potential impact on ambulance dispatch. Emerg Med J 2003; 20: 178-183.

Dean K. Self care behaviour: Implications for aging. In Self care and Health in Old Age: Health Behaviour Implications for Policy and Practice (Dean K, Hickey T, Holstein BE, eds). 1986. London: Croom Healm, pp. 58-93

Department of Health (2003) Building on the Best: Choice, Equity, Responsiveness.

Department of Health (2003) Configuring Hospitals: Ambulatory Care Plus.

Department of Health (2003) Developing NHS Direct: A strategy document for the next three years.

Department of Health (2003) How can we help older people not to fall again?

Department of Health (2003) Liberating the public health talents of community practitioners and health visitors.

Department of Health (2003) Shaping the NHS: Long Term Planning for Hospitals and Related Services. Response to the Consultation Exercise on the Findings of the National Beds Inquiry.

Department of Health (2004) Choosing health: making healthy choices easier.

Dost A (2005) Self Care - A Real Choice. Department of Health.

Dost A (2000) Views of the public on self care. Economics and Operational Research Division, Department of Health.

Dost A (1997) Towards a self care support strategy. Economics and Operational Research Division, Department of Health.

Forkner-Dunn J (2003) Internet-based patient self care: the next generation of health care delivery. J Med Internet Res 5 (2): e8.

Glasgow RE, Boles SM, McKay HG, Feil EG, Barrera M (2003) The D-Net diabetes self-management program: long-term implementation, outcomes and generalisation results. Prev Med 36 (4):L 410-9.

Healthwise Communities Self care Demonstration Project and its Evaluation. www.rwjf.org/reports/grr/029783.htm (accessed Jan 2nd 2004)

Jaarsma T, Halfens R, Huijer Abu-Saad H, Dracup K, Gorgels T, van Ree J, Stappers J (1999). Effects of education and support on self care and resource utilisation in patients with heart failure. Eur Heart J 20 (9): 632-3.

Judge TP. "Reforming Emergency Care" and ambulance services. Emerg Med J 2004; 21: 4.

Kennedy AP, Rogers AE (2002) Improving patient involvement in chronic disease management: the views of patients, GPs and specialists on a guidebook for ulcerative colitis. Patient Education and Counselling 47: 257-63.

Kerins M, Maguire E, Fahey DK, Glucksman. Emergency contraception. Has over the counter availability reduced attendance at emergency departments? Emerg J Med 2004; 21: 67-68.

Kralik D, Koch T, Price K, Howard N. Chronic illness self-management: taking action to create order. Journal of Clinical Nursing 2003; 13: 259-267

McClune T, Burton AK, Waddell G. Evaluation of evidence based patient educational booklet for the management of whiplash-associated disorders. Emerg Med J 2003; 20: 514-517.

Marks PJ, Daniel TD, Afolabi O, Spiers G, Nguyen-Van-Tam JS. Emerg Med J 2002; 19: 449-452.

Mayo Clinic. Special Report: The bottom-line importance of self care (2003). www.mayoclinichmr.com/research/selfcare_specialreport.cfm Accessed 7/2/04

Mead N, Varnham R, Rogers A, Roland M. What predicts patients' interest in the Internet as a health resource in primary care in England? J Hlth Serv Res Policy 2003; 8 (1): 33-39.

Modernisation Agency (2003). Improving the flow of emergency admissions – Key questions and action steps Networks for emergency care. Emergency care leads bulletin. www.doh.gov.uk/eclbulletin/bulletin7ecn.htm

Mullet J. (2000) Partnerships for better health: a self care pilot project. Final evaluation report. British Columbia. Ministry for Health.

Pelletier KR (1999) A review and analysis of the clinical & cost-effectiveness studies of comprehensive health promotion and disease management programmes at the worksite. Am J Health Promot 13 (6): 333-45.

Ralston JD, Revere D, Robins LS, Goldberg HI. Patients' experience with a diabetes support programme based on an interactive electronic medical record. BMJ 2004; 328: 1159-62.

Raymond B, Moon C. Prevention and treatment of overweight and obesity: toward a roadmap for advocacy and action. Permanente Journal 2003; 7 (4): 6-8.

Royston Dr GHD, Self care support: Presentation to the Departmental Board, Economics and Operational Research Division, Department of Health (1998).

Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, Watson R, Swain BE, Selby JV, Javorski WC. (1999) Diabetes management in a health maintenance organisation: Efficacy of care management using cluster visits. Diabetes Care 22 (12) 2011-17.

Salisbury C, Chalder M, Manku-Scott T, Nicholas R, Deave T, Noble S et al. The national evaluation of NHS Walk-In Centres. University of Bristol, 2002.

Sanford M, Byrne C, Williams S, Atley S, Ridley T, Miller J, Allin H. (2003). A pilot study of a parent education group for families affected by depression. http://www.cpa-apc.org/Publications/Archives/

Snooks H, Turner J, Woollard M. "Non-serious" 999 ambulance service callers. EMJ Online 2003 http://emj.bmjjournals.com/cgi/eletters/20/2/178

Turner J. Which calls come back? Medical Care Research Unit, University of Sheffield, 2003.

Victor CR, Peacock JL, Chazot C et al. Who calls 999 and why? A survey of the emergency workload of the London Ambulance Service. J Accid Emerg Med 1999; 16: 174-178.

Waxman R, Woodburn H, Powell M, Woodburn J, Blackburn S, Helliwell P. FOOTSTEP: a randomised controlled trial investigating the clinical and cost-effectiveness of a patient self-management program for basic foot care in the elderly. Journal of Clinical Epidemiology 2003; 56: 1092-1009.

Bibliography

Albisser AM, Harris R, Albisser J, Sperlich M (2001) The impact of initiatives in education, self-management training and computer-assisted self care on outcomes in diabetes management. Diabetes technology and therapeutics 3 (4): 571-9.

American Institute for Preventive Medicine. (2001) The health, economic and legal implications of medical self care programmes.

Appleton C, Summerbell C. Evaluation of the training provided by dietitians to group leaders of a pilot community-led weight management service. University of Teesside 2003.

Bates EA, Iakovidis I. (1999) Distance technologies for patient monitoring. BMJ 319.

Department of Health (2001) NHS Direct: A new gateway to healthcare.

Dr Foster (2003) Obesity management in the UK – a weighty issue for primary care organisations?

Geelong Hospital Perioperative Service Team (1998) Evaluation and Analysis of Pre-Operative Patient Education Through the Geelong Hospital Perioperative Service.

Health Development Agency (2003) Summary: The management of obesity and overweight: an analysis of reviews of diet, physical activity and behavioural approaches.

Kennedy A, Rogers A (2001) Improving self-management skills: a whole systems approach. Br J Nursing 10: 734-7.

McMorrin S (2004) 'Up For It' progress report.

Millard RW, Fintak PA. (2002) Use of the internet by patients with chronic disease. Disease Management and Health Outcomes 10 (3): 187-194.

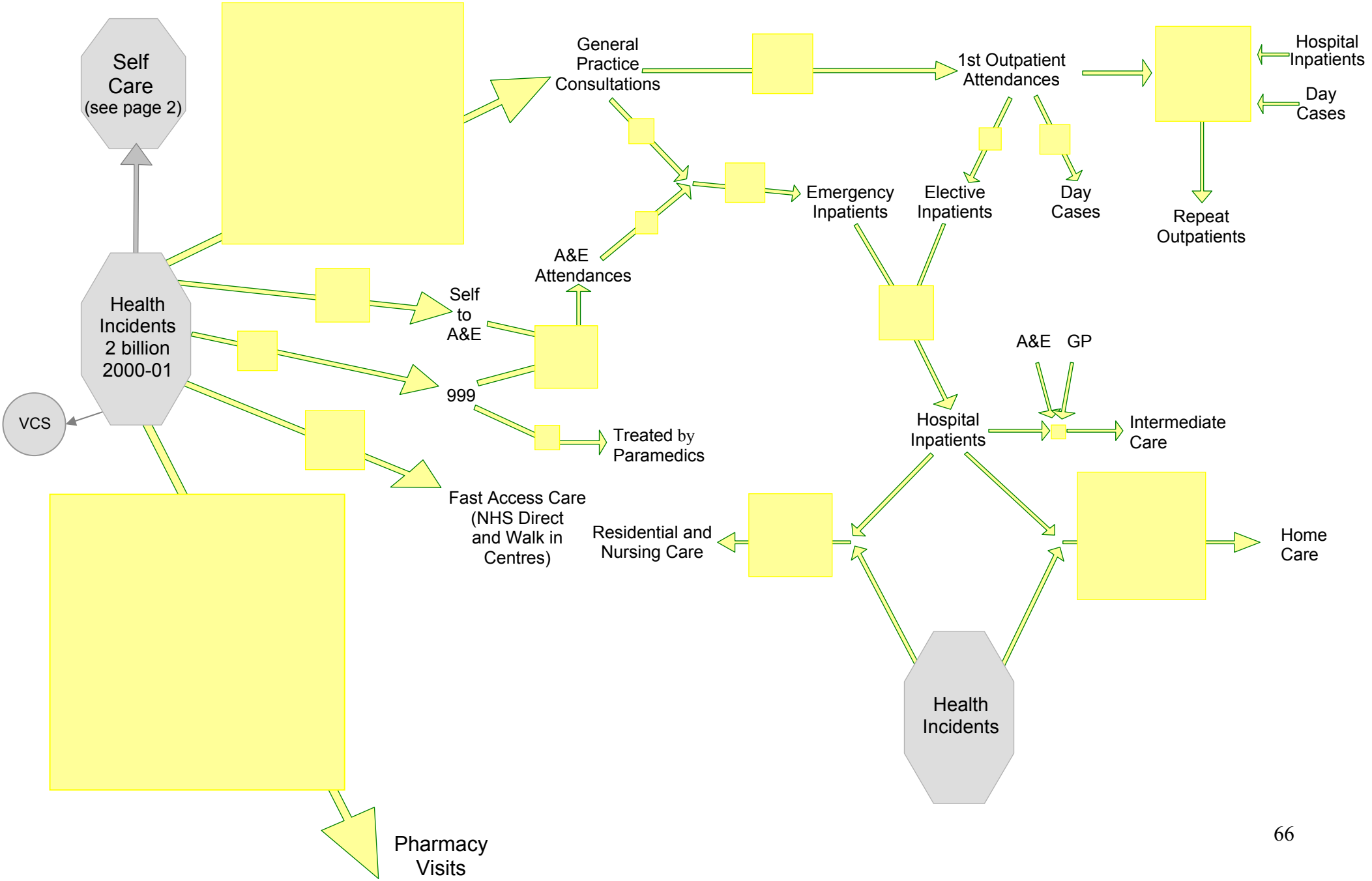
Niiranen S, Lamminen H, Niemi K, Mattila H, Kalli S (2003) A cost study of new media supported near oral anticoagulant treatment follow-up. International Journal of Medical Informatics 70: 19-29.

Port K, Palm K, Vilgimaa M (2003) Self-reported compliance of patients receiving antihypertensive treatment: use of a telemonitoring home care system. Journal of Telemedicine and Telecare 9 (Suppl 1): S1 65-66.

Strayhorn CK (2003) Use of internet-based technologies to manage chronic diseases. Special report to the Legislature. http://www.window.state.tx.us/specialrpt/etxaddnl/hhs22.html (accessed 15 Feb 2004)

Appendix 1

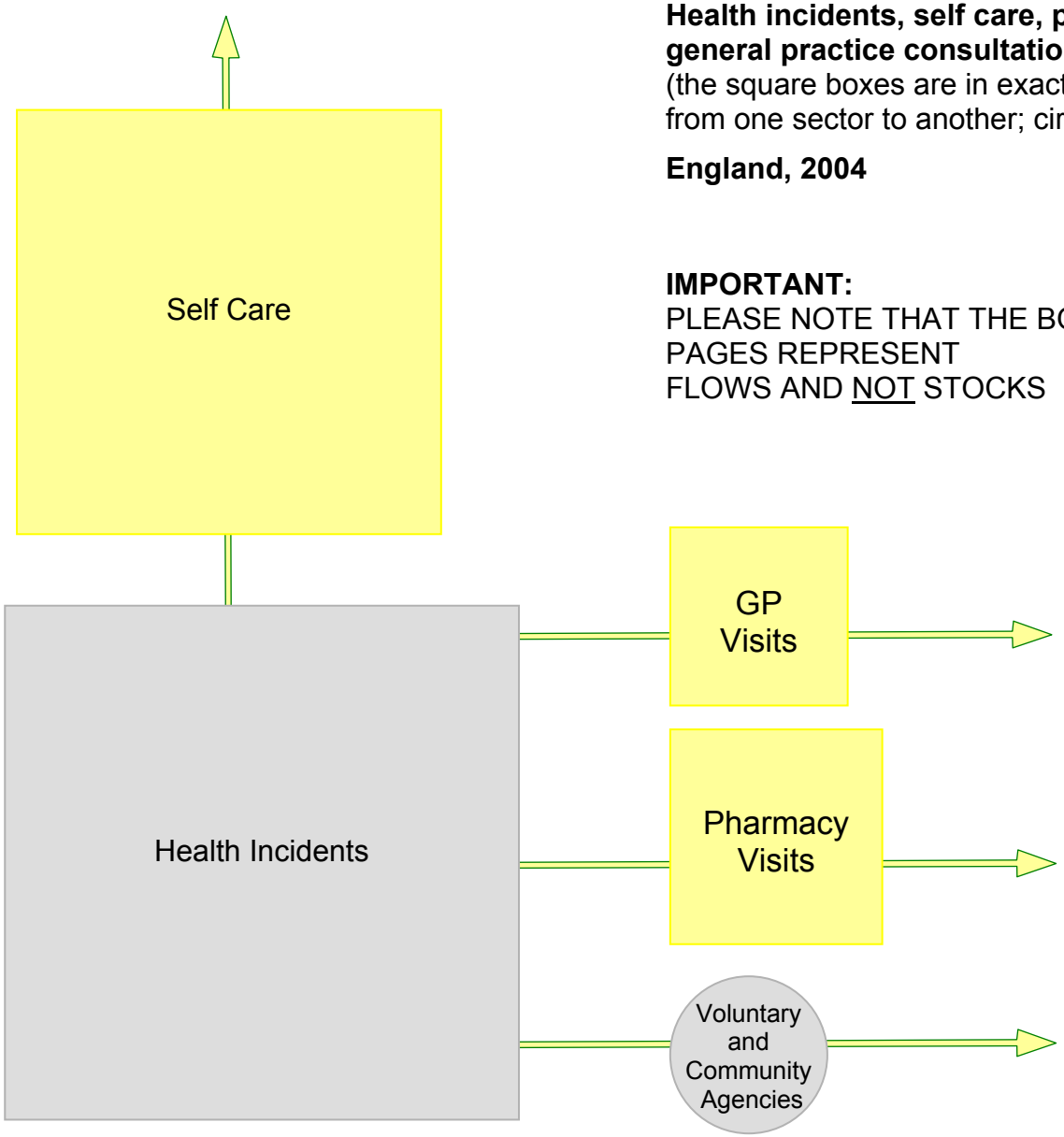
The Whole System of Care, England: activity levels represented diagrammatically (page i of iii)
(square boxes are in exact relative proportion to the size of flow of patients from one sector to another)



Health incidents, self care, pharmacy visits and general practice consultations:
(the square boxes are in exact relative proportion to size of flow from one sector to another; circle indicates size is not known, p ii of iii)

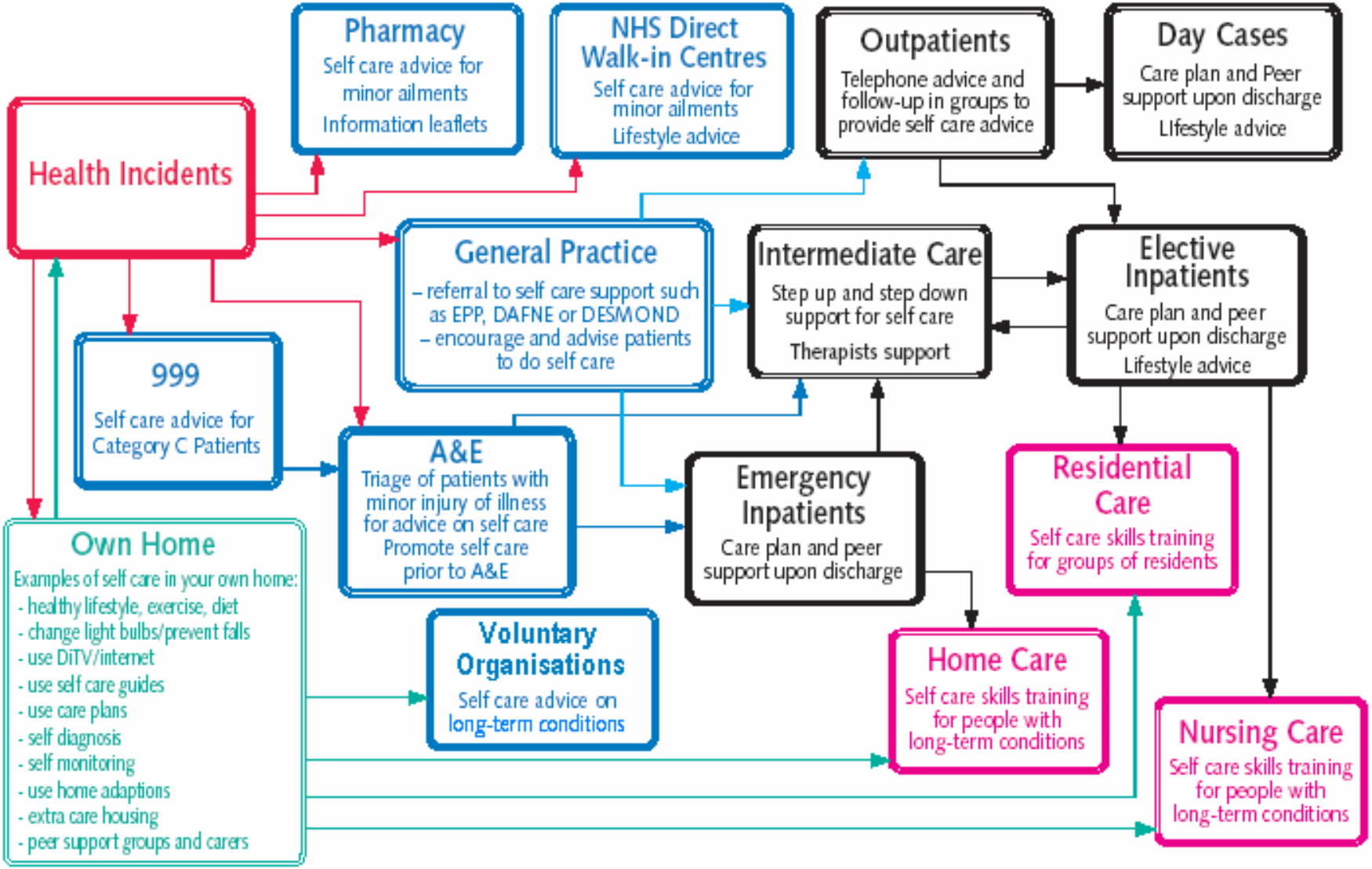
England, 2004

IMPORTANT:
PLEASE NOTE THAT THE BOXES ON BOTH PAGES REPRESENT
FLOWS AND NOT STOCKS



Ayesha Dost
April 1997
updated January 2005 with recent data

Self care support in the whole system of care (page iii of iii)



Appendix 2: Case study framework

- Description of the practice and setting
- Numbers of participants reached
- Types of participants by gender, age, geography, class, ethnicity etc
- Any evaluation data or other information on outcomes (for example, user feedback; impact on other services) including quantitative impact where such data are available
- Basic cost information
- Transferability and what would be needed to replicate the example more widely; any factors making an approach more or less difficult to spread; any risks in use of a specific approach.

Appendix 3: Summary of selected publications

Publication	Summary	Source/Contact
Supporting self care: A shared initiative Health Canada (2002)	Nine projects that supported professional health care practitioners striving to foster a change in attitude and behaviour among their colleagues through education, mutual support or demonstration of new models of practice and professional development were funded in Canada. Project teams developed various strategies and tools such as self care questionnaires for health care professionals and self care manuals to assist older adults in practising self care. The projects are described in the report.	http://www.cna-nurses.ca/pages/whats_new/self_care/supporting_self care__book.htm
Supporting self care: the contribution of nurses and physicians (1997) Romeder JM, La Perriere B, Chazan M, Chester B, Edwards P, Gillis N, Gros M. Health Care Network, Health Canada	Report of a study exploring how health care professionals can support or stimulate self care.	http://www.hc-sc.gc.ca/hppb/healthcare/pubs/selfcare/index.html
Supporting self care: perspectives of nurses and physician educators (1998) Romeder JM, Health Care Network, Health Canada	Report of two workshops; identifies the main barriers, and suggests avenues for action that can help nurses and physicians in encouraging and supporting self care.	
Can a disease self-management program reduce health care costs? The case of older women with heart disease. Wheeler JR. Med Care 2003; 41 (6): 699-701	Reports on controlled trial of the "Women take PRIDE" program in women aged over 60 with heart disease. A self-regulation process was used to address a problem area of the regimen recommended by each woman's physician. Inpatient days were reduced by 46% in the intervention group. Hospital cost savings exceeded program costs by almost 5 to 1.	jackwhee@umich.edu
The D-Net diabetes self-management program: long-term implementation, outcomes and generalisation results. Glasgow RE, Boles SM, McKay HG, Feil EG, Barrera M. Prev Med 2003; 36 (4): 410-419	Randomised intervention study of the effects of an internet-based health education program for patients with type 2 diabetes. 320 adults took part, who were relatively novice internet users. Improvements were observed across a variety of patients but usage declined over time.	russg@ris.net

Effects of education and support on self care and resource utilisation in patients with heart failure. Jaarsma T, Halfens R, Huijer Abu-Saad H, Dracup K, Gorgels T, van Ree J, Stappers J. Eur Heart J 1999; 20 (9): 632-33	Randomised trial of nurse-led education for older people with heart failure during hospital stay and then at home. Data were collected on self care abilities, self care behaviour, readmissions, visits to the emergency room and use of other health care resources. Self care behaviour was significantly increased in the intervention group.	
Do educational materials about self care and alternative care sites reduce emergency department visits by Medicaid beneficiaries? Rector T, Venus P, Laine AJ. Am J Managed Care 1999; 5 (12): 131-138	Evaluation of First Look, a programme comprising information provision on common illnesses, a self care guide (text written at 4th grade level) and toll-free nurse-led telephone helpline. Mailing information on the care of common non-emergency conditions did not significantly reduce the number of emergency department visits.	http://www.centerhcpe.com/researchfindings/rfjan2000.html
Patient education literature and help-seeking behaviour: perspectives from an evaluation in the UK. Milewa T, Calnan M, Almond S, Hunter A. Soc Sci Med 2000; 51 (3); 463-475	Evaluation of the effect of a booklet to support decision making by the public about common symptoms. Includes people's self-reported behaviour and perceptions about the booklet.	
What should I do? Go to the doctor? The role of a UK consumer self care resource in general practice casualty services after hours	Study of use and effects of the 'What should I do' booklet after face to face or telephone contact with a doctor out of hours in Australia.	http://innovations.adgp.com.au/site/index.cfm?display=169&PageMode=indiv&pageid=514&keyword=child
Internet-based patient self care: the next generation of health care delivery. Forkner-Dunn J. J Med Internet Res 2003; 5 (2): e8	Review of use of the internet to support self care. Comment on doctors' reasons for not promoting internet use by their patients.	June.forkner-dunn@kp.org Internet Services Group, Kaiser Foundation Health Plan

A patient education MAP: an integrated, collaborative approach for rehabilitation. North MC, Harbin CB, Clark KG. Rehabil Nurs 1999; 24 (1): 13-18	Development of a patient education plan for "learning the skills required to provide safe and competent self care in the home". Use of Multidiscipline Action Plan (MAP) to provide a framework linked to expected outcomes of education.	
Chronic illness: reflections on a community-based action research programme. Koch T, Kralik D. J Adv Nurs 2001; 36 (1); 23-31	Development of community nursing support for patients with MS, urinary incontinence and type 2 diabetes to facilitate self care.	
Health care professional support for self care management in chronic illness: insights from diabetes research. Thorne SE, Paterson BL. Patient Education and Counselling 2001; 42 (1): 81-90	Study of the development of self care decision making expertise in adults with longstanding Type 1 diabetes. Identifying ways in which health professionals' interactions support or fail to support patients' self care.	
Distance technologies for patient monitoring Balas AE, Iakovidis I, BMJ 1999; 319: 1309-1311	Summary of use of technology in patients' homes for monitoring in diabetes, hypertension and its role in increasing patients' involvement in their own health care.	Abalas@health.missouri.edu
Geriatric rehabilitation following fractures in older people: a systematic review Cameron I et al, Health Technology Assessment programme 2000; 4: 2	Review published evidence of effectiveness and cost-effectiveness of programmes of care and rehabilitation following the acute care of fractures in older people.	
Wagner TH, Hibbard J, Greenlick MR, Kunkel L. Does Providing Consumer Health Information Affect Self-Reported Medical Utilization? Medical Care 39(8): 836-847, 2001	Evaluation of the Healthwise Handbook and supporting resources.	
Hibbard J, Greenlick M, Jimison H, Capizzi J, Kunkel L, The Impact of a Community-wide Self care Information Project on Self care and Medical Care Utilization, Evaluation & the Health Professions, 24(4), 2001, 404-423	Evaluation of the Healthwise Handbook and supporting resources.	