A REVIEW OF SELF MANAGEMENT SUPPORT INITIATIVES IN DONEGAL
Ms Lynn Stoddart, Nurse lead Long Term Conditions, Donegal

BACKGROUND
Self management support programmes have been shown to reduce hospital admissions and to support people in adhering to medication and treatment plans. With the right type of support, the vast majority of people with chronic conditions can be enabled and empowered to effectively manage their condition and improve the quality of their lives. The question is not whether people with chronic conditions manage their conditions, but how well they manage2.

From 2010-2014 a number of innovative and successful programmes have been piloted and subsequently implemented in Donegal that offer a unique service to local communities and are consistent with the goal of “Healthy Ireland” to promote health and well being at all stages of life and support self management.

However these programmes are independent of each other, with various funding sources and governance arrangements. A review was commissioned by Mr John Hayes in January 2014 to review these initiatives and identify a more integrated approach to programme delivery. The review took place from February to April 2014

AIM
The aim of the Self Management Support review was to help in developing a more integrated approach to nine identified programmes in Donegal that enable and empower people to manage their own health.

OBJECTIVES
• To complete an overview of self care internationally and in Ireland
• To describe current self management programmes in place in Donegal
• To make recommendations for a more cohesive integrated approach to self management programme delivery

Each of the nine programmes included in the review were examined in terms of:
• Scope, range, scale and model of delivery of the nine programmes
• Partnership arrangements and pathways supporting the initiatives
• Resources including financial resources deployed
• Evidence base and evaluations completed
• Areas for integration of the programmes

REVIEW PROCESS
An open and collaborative approach was taken to this review process and had two components:

QUANTITATIVE
This involved design, completion and analysis of the results from a comprehensive Self Management Support (SMS) Survey tool

QUALITATIVE
The process commenced with a meeting of key stakeholders to share information on the initiatives involved and to provide an opportunity for input into the review process. One to one meetings with programme co-ordinators for more in depth discussion and clarification.

RECOMMENDATIONS FOR PROGRAMME INTEGRATION IN DONEGAL

<table>
<thead>
<tr>
<th>ORGANISATIONAL GOVERNANCE MANAGEMENT AND STAFFING</th>
<th>SUPPORTING STRUCTURES</th>
<th>EVIDENCE BASE AND QUALITY ASSURANCE</th>
<th>TRAINING</th>
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</thead>
<tbody>
<tr>
<td>Establish an Integrated governance structure that leads and supports current and future programme development and delivery across Donegal, with wide representation from key stakeholders (to include patient advocacy)</td>
<td>Develop a combined timetable of programmes quarterly, this will involve advance scheduling of all programmes</td>
<td>Provide a common quality assurance and evaluation framework for all programmes</td>
<td>Provide joint training sessions covering core knowledge and skills for programme leaders. Utilise these opportunities to exchange information and build links between programmes.</td>
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PROGRAMME COORDINATION AND REFERRAL PROCESSES

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<tr>
<th>PROGRAMME COORDINATION AND REFERRAL PROCESSES</th>
<th>MONITORING AND REVIEW</th>
<th>INTERNAL COMMUNICATIONS</th>
<th>EXTERNAL COMMUNICATIONS</th>
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<tbody>
<tr>
<td>Develop a single point of access to all programmes</td>
<td>Develop common tracking, monitoring and reporting mechanisms across the programmes</td>
<td>Develop common evaluation and review processes that take account of all programmes</td>
<td>Develop a collaborative marketing strategy to promote the programmes including the development of cross programme material.</td>
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NOME OF PROGRAMME/INITIATIVE | QUALITY OF LIFE | GREEN PRESCRIPTION | SOCIAL PRESCRIBING | SMOKING CESSATION | CARERS | SOLAS | MEET | DESMOND |
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<tr>
<td>Target Population (Individual approach/ population prevention approach)</td>
<td>Person living with chronic conditions</td>
<td>Over 18 yrs with a health problem</td>
<td>People with mental health difficulties or who feel isolated</td>
<td>Anyone who wants or needs to stop smoking</td>
<td>Two programmes 1. Carers of people who have had a Stroke 2. Generic programme with focus on dementia &amp; MS</td>
<td>Mental Health Service Users</td>
<td>Children under 6yrs; 7-12 yrs; whole family approach</td>
<td>All recently diagnosed Type 2 Diabetics</td>
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<tr>
<td>Programme Group/Individual</td>
<td>Group based</td>
<td>Individual</td>
<td>Group based</td>
<td>Group based</td>
<td>Group based</td>
<td>Family based</td>
<td>Group based</td>
<td></td>
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<tr>
<td>Geographic Area covered (by network/area in Donegal)</td>
<td>All Donegal</td>
<td>All Donegal</td>
<td>An tArdara/Glenntaffany/ Falcarragh/ Creeslough Downings/Carrigtwohill Railway Hse L.Kenny Donegal Town Buncrana</td>
<td>All Donegal with 2 clinic locations in each network</td>
<td>All Donegal</td>
<td>North West Donegal</td>
<td>Letterkenny Lagan &amp; North Inishowen (2014)</td>
<td>All Donegal</td>
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<tr>
<td>Aims &amp; Objectives of the Programme/Initiative</td>
<td>Provision of self management education to empower people to self manage</td>
<td>Increase the fitness levels of target population &amp; thus reduce problems associated with obesity, hypertension, stress &amp; depression</td>
<td>Improve mental &amp; physical health through participating in Community based activities &amp; other non medical supports</td>
<td>Looks at physical, psychological &amp; behavioural reasons for using tobacco &amp; develop a treatment plan in consultation with client</td>
<td>Looks at motivation &amp; behavioural change</td>
<td>To promote confidence reduce levels of stress as experienced by carers To enable the person to remain living at home for as long as possible Increase family carer understanding of condition the person is living with</td>
<td>Core purpose is to provide opportunity for recovery &amp; re-emergence. Restore confidence; break isolation; withdrawal &amp; inactivity Support people towards autonomy &amp; self governance</td>
<td>Improve family health &amp; wellbeing &amp; developing healthy life skills through a multi component prevention &amp; management programme addressing lifestyle activity.</td>
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<td>Referral Pathways (to/from)</td>
<td>Clinician referral (To QOL co-ordinator)</td>
<td>Clinician Self referral to Green Prescription support worker</td>
<td>Clinician Self referral to social prescribing co-ordinator</td>
<td>Clinician Self referral</td>
<td>Clinician Self referral Family resource centres to Carers development officer</td>
<td>Clinician Self referral Training &amp;Occupational Support Services (TB&amp;OSS)</td>
<td>Clinician Childcare organisations</td>
<td>Clinician referral to Dietician services</td>
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REFERENCES: