



**S**ELF  
**M**ANAGEMENT  
**A**WARENESS  
**R**AISING  
**T**OOL

*Coming together is a beginning. Keeping together is progress.  
Working together is success.*

# Self Management...

## ...why bother?

People with Long Term Conditions continue to tell us that they want more information and support to help them manage their condition themselves.

They want and deserve **"More support for self care!"** They also want to be seen and treated as a person with a Long Term Condition not a Long Term Condition label; **"a person with diabetes"** and not **"a diabetic"**. The NHS must listen and provide this approach and support which not only delivers better outcomes and better experience but which also happens to be more affordable and sustainable.

**Dr. Steven Laitner, Clinical Co-Chair of the Long Term Conditions Programme Board, NHS East of England**

# I am not a statistic!

Remember that television show from the sixties? The Prisoner.

The central character, known as 'Number 6', constantly endeavours to escape from enforced conformity, with his strong defiance of "I am not a number," he repeatedly declares, "I am a free man."

This simple statement **"I am not a number"** can be equally applied to the NHS **"I am not a condition, I am a person"**. I am not an asthmatic or a diabetic; I am not defined by my condition, I am me, a person who happens to have some long term conditions which sometimes impinge on my life and the way I live it. **But I need support.**



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# Patient Perspective Principles

- I need to be treated like a person and not a set of diseases all in one body.
- I need to be listened to.
- I need information so that I can understand.
- I need to know how the condition will impact on my life.
- I need to know what I can do to help myself.
- I need to feel supported and that someone understands my concerns.
- I need to know what all of my options are.

I want to know what my journey will be like.

## PCT Story – A patients view

*“Some people change when they see the light, others when they feel the heat.”*

One of my favourite songs to listen to when going on a drive is “You’re Not a Number.” by Chris Rea. This is how I like to feel when I’m talking to a GP about my health.

I like to feel that I’m not a number, not just another patient, but I’m me. I have a name, a personality, hobbies, interests. I’m much more than just a condition, but often I find that I’m labelled with M.E. It’s like some people only see me as an M.E sufferer, and not a person that just happens to have M.E. It’s so nice to speak to a GP who really wants to listen, who doesn’t just interrupt all the time with question after question, but gives me time to think about my answers. It really does make me feel more valued when they spend the time talking to me.

I remember when we were talking about which treatment method to try. He told me about all the different options, but gave **me** the choice. We talked about the pros and cons for each one, before settling on one that would suit my lifestyle and fit in with my daily routines.

I have been to see a few doctors, and had varying levels of success. I’ve also heard some horror stories from people that end up on the wrong medication because the doctor doesn’t listen to their needs and to what they say. When I hear these I just feel so lucky; **I’m treated like a person, and not just a number on the system.**

## GP Story – Dr Vincent Forte GP

Just over a year ago, I was invited to join the East of England SHA Long Term Conditions (LTC) Programme Board and, soon after that, the Personal Health Plan Working (PHP) Group.

Prior to this I had been a GP who moaned a lot about people not looking after themselves well, regularly regurgitating all the traditional and time-honoured whinges of GPs everywhere. I had no interest in anything beyond doing my surgeries and getting home. That seemed to be enough.

But it wasn’t.

I have become enthralled not just to watch, but be involved in the brave new initiatives of Self Care and Partnership Working that underpin a complete paradigm shift in medical care in the UK. This involvement has given my whole job as a GP a new perspective, putting what I do day-to-day into context within a much bigger picture of the unimaginably vast organisation that is

the NHS. It’s akin to looking up at the stars and suddenly feeling very small –but appreciating the world you are in all the more. The planet I live on is much more interesting for appreciating the mechanics of the universe around it.

Developing the tools that will effect this change, such as PHPs, and training in self-care for Health Professionals, is only the very start of this fundamental change in the Philosophy of Medicine. The real work is about to begin – the culture change. Without this culture change, the tools will be useless. Tools are used for a purpose, and the use and purpose are governed by behaviours. If a culture doesn’t require certain behaviours, then they will not be used. If certain tools are only used in certain behaviours, then they will not be used.

**“We have built and are building some of the tools we need to make a different sort of Health Care. It is vital we turn now to changing culture to nurture the behaviours vital to Self-Care so that these tools are used.”**

# Seven Principles of Self Care

## Sarah Wood Self Care Programme Development Facilitation

- Ensure individuals are able to make informed choices to manage their self care needs.
- Communicate effectively to enable individuals to assess their needs, and develop and gain confidence to self care.
- Support and enable individuals to access appropriate information to manage their self care needs.
- Support and enable individuals to develop skills in self care.
- Support and enable individuals to use technology to support self care.
- Advise individuals how to access support networks and participate in the planning, development and evaluation of services.
- Support and enable risk management and risk taking to maximise independence and choice.

Research has shown that by becoming more effective and supportive communicators, clinicians can significantly empower people to manage their long-term conditions with confidence. The skills developed by the programme may contribute to a decrease in recurrent patient consultations, home visits and ultimately hospitalisation. The focus of the training is to develop the communication, coaching and mentoring skills of clinicians in order to enable them to support individual patients in risk management and decision-making. This includes providing effective access to reliable information through communication

technology as well as access to and the evaluation of support networks.

Having worked within the NHS for thirty years I confess whilst agreeing with the principles of the self care project I viewed the initiative with a scepticism befitting my experience.

After attending the workshops I realised that my cynicism was unfounded; I was impressed and saw a shift both within myself and the attitude of fellow clinicians. I have since put these new skills into practice and have been astonished at my ability to engage with and empower the patients at my practice. Each patient responds differently. The self care principles are seated within a spectrum so that some patients embrace full autonomy and some make small changes to their own management often with significant and visible results.

*What we really mean!*

*Review and Comment:*

*"You do the dirty work so I can forward it"*

## NHS East of England

### Lucy Dennis Workforce Development Consultant

NHS East of England has also developed a '6 Step Guide to assessing your PHP skills' for staff. They should:

- 1 Familiarise themselves with the PHP Competency Domains
- 2 Identify their PHP competency development areas
- 3 Incorporate PHP objectives to a development plan and identify key learning materials
- 4 Develop a portfolio of evidence to illustrate competence

- 5 Align PHP objectives to performance development reviews
- 6 Meet requirements of regulatory bodies and clinical governance

Implementation of the tools and resources will take place during October – March 2010 via series of county based workshops, as well online support through a regional virtual network.

*It is not just about ticking boxes, it is about really changing the focus of the consultation process between the healthcare professional and the person with a long-term condition, empowering them to take control of their care.*

# Pressure on the NHS

Dawn Jermany, Practice Manager



It is a well known fact that patients with long term conditions can place significant pressure on resources provided by the NHS. Not only do these patients tend to be frequent visitors to their GP surgery but evidence shows they are

more likely to be admitted to hospital and in general tend to stay there for longer.

With increased opportunistic screening being promoted for the future, the number of patients being diagnosed as suffering from a long term condition is likely to increase. In order for General Practice to cope with this predicted increase it is vital that primary care staff are sufficiently trained to ensure patients receive the correct information, education, support and encouragement to enable them to learn more about the management of their condition and to have the confidence to manage their own care thus helping to avoid health crisis.

It is important for patients and professionals to work together sharing good practices and for innovative approaches to be developed to provide patients with the necessary skills to help them cope better in the future. Not only will this lead to less pressure on GPs, Practice Nurses and the demand for appointments but will lead to improved health outcomes and quality of life for patients.

## Supporting Self Care Programme

Sarah Wood Self Care Programme  
Development Facilitation

An aging population means an increase in chronic disease

The Twenty-First Century has brought about unprecedented changes to modern life, arguably none so significant as in the delivery of health care. People now anticipate a significantly increased life expectancy which means the population suffers from more long term conditions such as diabetes, chronic obstructive airways disease and cancer. The imperative to manage chronic disease more effectively has made a substantial impact on the workload of the primary care team in terms of both time and money. It has become increasingly apparent that this cannot be sustained long term and as a result demands a strategy to cope with a growing work load; one that uses available resources to their best advantage.

Patients are informed by the Internet

The Internet has provided patients with unlimited access to information regarding their health. However not all the information is correct let alone accurate which is potentially

dangerous to a patient managing chronic and life threatening disease. This smattering of information also paradoxically contributes to the growing culture of dependency that patients exert on health professionals. Clinicians increasingly need to be ready to answer questions and dispel fears and misconceptions as well as guide their patients in decision making and risk management.

Self Care programme

The East of England Self Care Programme, developed in partnership with the Health Foundations Co-Creating health initiative, offers an inter-disciplinary training programme in communication skills for the whole general practice team.

The course is free and is an excellent team building exercise. It counts towards individual PREP and learning portfolios and may be arranged at a convenient time and location for the team. The training comprises of three two-hour training sessions usually at monthly intervals and involves patient satisfaction surveys as a means of evaluation both prior to and on completion of the course.

# Strategic View

## Lucy Dennis Workforce Development Consultant

Due to an ageing population, it is estimated that by 2025 there will be 47% more people in East of England aged 65 or over. This will mean that the number of people with at least one LTC will rise by 300,000 to 850,000. The East of England's regional agenda is ambitious. All primary care trusts will be required to offer Personal Health Plans to two LTC patient groups by March 2010, a further 3 LTC patient groups by September 2010 and to all LTC patient groups by December 2010.

NHS East of England along with individuals with LTCs, their carers, health and social care colleagues and representatives from the third sector, have worked hard over the past 18 months to understand the best way to implement Personal Health Planning (PHP). **Following initial consultation & engagement events the East of England have adopted the term Personal Health Planning as they feel this best reflects a more collaborative approach.**

The SHA hope that Personal Health Planning will empower individuals to take greater ownership and responsibility for their care and the management of their condition, it advocates an empowered and less paternalistic approach to the management of LTCs. The process starts with an understanding of the principles of PHP. These have been described as part of the PHP Journey which includes the *preparation* of supporting an individual to understand what PHP may mean for them, supporting individuals to create a Personal Health Plan and enabling individuals to *live with PHP* through the realisation of personal goals.

The personal health plan is a tool, which records the outcomes from the planning session between the individual and their key

worker. The plan is owned by the individual and contains all the information an individual needs to manage their own care.

In March 2009 NHS East of England began a PHP pilot across 15 sites to test the Personal Health Plan tool and to start to explore key components of the workforce PHP workforce guide. Findings from the pilot sites showed that the SHA needed to review the Personal Health Plan tool, develop a communications plan and stakeholder engagement strategy, and identify staff capability, aligning this to current workforce systems.

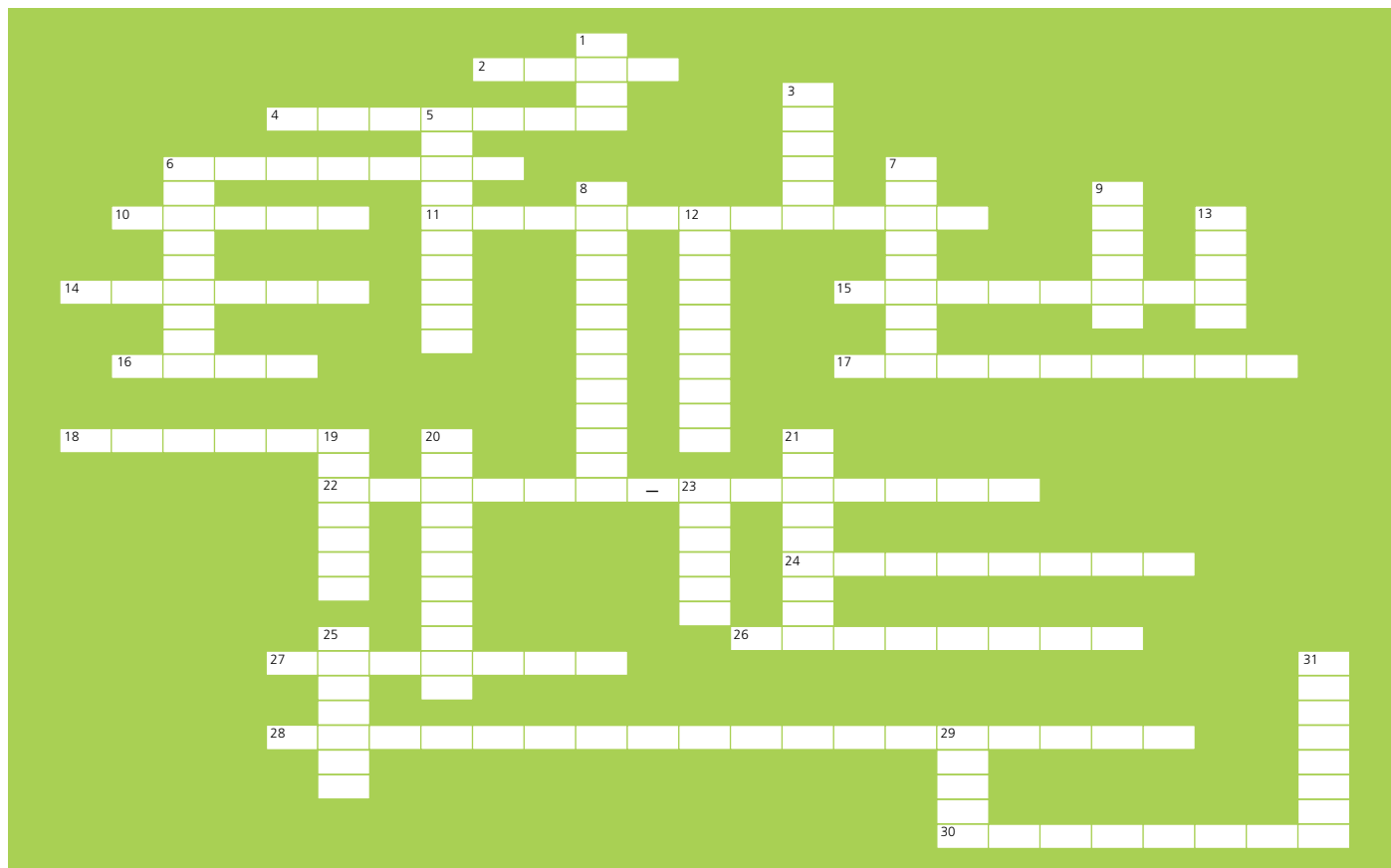
In October NHS East of England launched a series of tools and resources to support organisations, teams and key workers to implement PHP. The Personal Health Plan tool and supporting guidance outlines a regional framework for capturing and recording the outcomes from the discussion between a key worker and an individual.

NHS East of England, in partnership with Capgemini, developed a regional workforce guide; Understanding Personal Health Planning: A Workforce Guide to Support People with Long Term Condition. The interactive guide consists of three key components; PHP Journey, PHP Competencies and a 6 Step Guide to Developing your PHP Skills.

*Real Meanings:  
Essentially complete:  
"I've started it"*



# Crossword



## Crossword vertical clues

- 1 Service provided to patients
- 3 Someone with special skills or knowledge
- 5 Full trust and belief
- 6 Plan of action to a specific end
- 7 Facts known to a person
- 8 The exchange of thoughts and ideas
- 9 Active, thriving
- 12 Handling and controlling a condition
- 13 Special ability
- 19 Give authority to
- 20 A collaboration
- 21 State with regards to health
- 23 When you have more than one option
- 25 A group of people helpful to one another
- 29 Useful devices to implement
- 31 Indications of a condition

## Crossword horizontal clues

- 2 Scheme
- 4 The end achievement
- 6 A person undergoing medical treatment
- 10 Aim to complete these
- 11 Useful knowledge
- 14 Condition of the body or mind
- 15 Intended for the use of one individual
- 16 Singular unit of being
- 17 Tools needed to accomplish an end
- 18 Opinion offered as your guide
- 22 Humanistic
- 24 Instructing a person, guidance
- 26 Helping someone to help themselves
- 27 Aid to a plan
- 28 Such as diabetes (3 words)
- 30 To hold up

*Answers to the crossword will appear in the next issue.*

## NHS Norfolk has defined the Self Care Model of Choice as one of the key initiatives identified by the LTC team within the strategic area:

Prevention and Maintaining independence. This piece of work has been reflected in our operational and strategic commitments, and crystallized with a £100,000 budget for 2009.

The model aims to provide a menu of options that reflects individual patient choices in relation to self management and self care. This framework has been conceived following recent Year of Care developments. The menu of options is the result of a systematic approach where information about individual's priorities and goals is captured and fed into commissioning at population level.

From the commissioning perspective, the framework aids decision making when assigning resources by means of coefficients. The coefficients will converge to reflect PPI, a mapping exercise and a gap analysis. Once streams of money have been identified, interested parties (mainly third sector) are going to be invited to express their interest and work as key partners in the delivery of the model. Lilly (pharmaceutical company) will give support in facilitating the event with stakeholders. From the patient perspective, the menu of option might take the form of:

**Information – website project, structured education programmes, telephone review/support/coaching, navigator role, exercise programmes, self help groups, assistive technology.**

# NHS Bedfordshire's Staying in Control Personal Health Budget Pilot

Staying in Control is a learning community of 37 PCTs (including NHS Bedfordshire) and their partner Local Authorities who are exploring how the Personalisation Models tested in social care including Personal Budgets can best be amended and tested within the NHS.

NHS Bedfordshire are running an 8 month pilot with a small number of new Stroke Survivors, who are supported by BCHS Rehabilitation and Enablement Team, or Acquired Brain Injury Team and who are reaching the end of their 'formal' rehabilitation, and beginning to make decisions regarding their longer term health and well being needs.

The participants consent to being part of the pilot and then create a Personal Health Plan with the help of the Health and Social Care professionals who are supporting them. They are asked to identify positive health and wellbeing outcomes and how they believe they can use their Personal Health Budget to achieve these.

As this is a new concept for many health professionals a Risk and Innovation Group has been set up to provide a multi-disciplinary/ multi-agency forum to stimulate innovation, provide support for professionals participating in the pilot, and formally authorise the Personal Health Budgets.

For the purpose of the pilot a set notional budget has been identified for each participant, which is held by NHS Bedfordshire. The pilot 'went live' on 1st July 2009, and following an initial slow start we now have two participants with Personal Health Budgets and three cases which are pending. There have also been two potential participants who declined to participate. As a result, NHS Bedfordshire has been chosen as in-depth evaluation site for the DH Personal Health Budget Pilot Programme.

**For further details please contact Gillian Turrell – Commissioning Manager (Older People)**  
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## NHS North East Essex Health Plans

# NHS North East Essex PHP development

NHS North East Essex is embracing the development of Personal Health Plans for members of their local community with a long-term condition. The PCT is exploring working in partnership with Triangle Consulting to draw up a Personal Health Star, a visual tool which helps the person to identify areas of concern, and develop actions for improvement. Other versions of the Outcome Star are in use across public and third sector organisations, including mental health, homelessness and substance misuse.

The tool, which is recognised by the Audit Commission and enthused about by those who have experienced its application, is an holistic approach, with the potential to cover a breadth of lifestyle factors influencing a person's management of their condition and quality of life (e.g. emotional health, finances, physical health). The development of a PHP version would include structured workshops with patients, carers and healthcare professionals, so as to identify the relevant star points and underlying journey of change. As it is a mainly pictorial model, it is hoped that the Star would not only present an easily accessible PHP, from which clear and manageable actions can be identified, but would complement existing written and narrative based care documents.

**For further information, please contact Ali Connolly, Assistant Commissioning Manager, at NHS NEE**

# A note from Acorn Surgery...

## ...the first Self Care Pilot practice



Some members of our Acorn Surgery team

As the initial pilot practice for the Self Care Project, we regarded involvement in the training as an opportunity to be at the forefront of a significant programme of change within primary care in the East of England. In spite of considerable pressures on staff time, we felt the project might offer us an opportunity to make practical improvements in patient care and, as a progressive Practice with an enthusiastic team, it could also be used as part of our Practice development planning and team building initiatives.

Our action-learning process lasted seven months from May – November 2008. It was kick started by a series of 3 interactive workshops. Initially these were planned to include just doctors - but feedback from the Acorn team pointed out that everyone was involved in dealing with long term condition patients. In reality the bulk of routine consultations would be carried out by the nursing team - but what had not been appreciated was just how much contact our reception & admin team also have with this cohort of patients - dealing with numerous queries in person, by phone and email, not to mention having to listen to their shared concerns, anxieties and hopes for the future.

It is fair to say that there was a degree of cynicism from some doctors - all 4 partners are approved GP trainers and felt they probably knew everything about consultation technique - but of course knowing and doing are quite separate things!

In reality the three workshops facilitated by a clinician and an actor (with multiple personalities!) proved to be a catalyst in rekindling enthusiasm across the entire team and all participants proved very willing to test out their skills, particularly exploring barriers to lifestyle changes and motivating patients. These training sessions created space for reflection and feedback from members of the multi-disciplinary team and the skills learnt were put into practice between each of the training sessions.

We regarded it as fundamental that our admin and reception colleagues were involved in the process; as front-line staff they are in a position to be the first port of call for patients with long term conditions and, as such, are directly involved in service delivery. It's vitally important that they have well-developed communication and empathy skills in order to best serve the needs of these particular groups of patients. Care and understanding of a patient's changing needs are necessary to promote wellbeing and to offer a holistic approach to care.

Developing focussed in-house training sessions was a stimulating challenge for the Practice Manager but our colleagues in Admin & Reception continue to be wholly supportive of the concept and embrace it with surprising enthusiasm. Their development work is ongoing, producing and providing a range of resources for patients with different long term conditions. Their improving skills help them to better engage with people with long term conditions, and their approach and thinking in general has taken on a much more positive stance as a result of our Practice's involvement in the Self Care Programme.

We see ourselves as only part way through the journey of supporting our patients in self care but involvement in this project has certainly given us an opportunity to take stock, reflect on our approach - both clinical and administrative - and modify our ways of working, ultimately delivering an improved service to patients. It has been heartening to see other Practices gradually get on board over this past year - and we are sure they will find similar benefits those realised within in the Acorn Surgery. Our next step is to develop a dedicated section of our website ([www.acornsurgery.com](http://www.acornsurgery.com)) to supporting patients with long term conditions, signposting a range of resources and events which may be of relevance or interest to them and their carers.

# Self Care/Management Initiatives

NHS Suffolk commissioned “BME living with diabetes” events in response to local community requests. The main aim was to equip the local community by raising their awareness and their ability to self-manage diabetes better. ‘The local African Caribbean community was the first ‘pilot’ group

The local African Caribbean community were key in terms of partnership working, engagement and in helping us understand what they specifically wanted to know about living with their diabetes and accessing health care.

This initial process of engagement took the form of a letter/questionnaire (with prepaid envelopes as required), one to one and group discussions. We introduced ourselves and the forthcoming event, and also asked for suggestions on the content of the programme (i.e. what topics they would like discussed, venue, time of year and how to market and communicate the event within the local community).

The feedback from the questionnaires and discussions with the local community not only generated common themes around lifestyle and self management but also some confusion/myths.

## Questions asked included:

- *‘What is diabetes?’*
- *‘What is the difference between Type 1 and Type 2?’*
- *‘How do insulin and ‘diabetic tablets’ work?’*
- *‘What Caribbean food can you eat?’*

## about portion control and calorific values,

- *‘How do I take care of my eyes and feet?’*
- *‘How can I lose weight?’*



This was very useful for the facilitators planning the programme. It gave us insight into what the community felt about their diabetes and what they wanted to know.

Several ‘champions’ from the group assisted with the communication and marketing. This included, local businesses i.e. shops, barbers, hairdressers, churches, clubs and education establishments.

The programme was then tailored to fit their criteria. We had to revisit and revise the programme several times so that it became more interactive and semi structured to suit the delegates. The event was also timed to coincide with the annually celebrated ‘Black History Month’.

The feedback from the delegates include: An ‘Excellent’ event. ‘The Food workshop was very good I learnt a lot’. When asked, ‘How would you like to see diabetes care developing in Ipswich?’ ‘Because of the increase in diabetes, it is necessary to develop the care.’

‘How will this event help you self-manage to improve your diabetes control and quality of life?’ ‘My doctor is doing a great job with me but this event will help a lot to improve my health.’

The programme can be adapted for the other events e.g. The Indian, Chinese and Polish communities.

1. This supported the World Class commissioning Best Practice Guidance competency 3 ‘Proactively build continuous and meaningful engagement with the public and patients to shape and improve health’.

## What are the benefits... ...of the self care pilot for your practice?

- Free training for the whole practice team (including nurses, admin staff, allied health professionals, practice managers and doctors) with patient feedback reports and contribution to locum costs and backfill
- Contributes to QOF points
- Improved quality of patient consultations
- Can form a component of personal development plans and appraisals
- Improved patient satisfaction
- Reductions in doctors' visits
- Significant long-term improvements in self management
- Significant reductions in Accident and Emergency attendances and hospital admissions
- Safer and reduced medication intake and improved utilisation
- Increasing evidence of impact on people living with conditions such as : arthritis, asthma, cancer, coronary heart disease, diabetes, obesity, pain, stroke
- Supports personalised care and personal health plans
- Supports carers
- Opportunity to be part of a leading edge development in the transformation of primary care

## Who do I contact further information?

Julie Yaxley, Programme Manager,  
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Tom Leach, Workforce Development Consultant,  
NHS East of England  
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## How does it work?

The programme works directly with general practices and practice based commissioning groups across the East of England.

It is coordinated by a small unit at NHS East of England led by a Self Care Programme Manager. Practice Development Facilitators are available to provide advice and support to interested practice teams. A team of specially trained tutors and patient co-facilitators lead practice-based workshops and supply on-going development support.

We aim to build a network of 50 mutually supporting practices by December 2009 and to complete systematic impact evaluation which will develop the evidence base for success.

## What is the programme designed to do?

The programme is implementing seven core principles of self care with primary health care teams in the east of England region.

It includes a four month process of learning, action and follow-up with multi-disciplinary teams in the practice environment. The process is highly practical and has a strong focus on how to make the best use of limited consultation time. Training workshops facilitated by expert clinicians and patient co-facilitators help to build effective partnerships in each practice between clinical staff and patients.

## What are the commitments?

- Attendance at an initial briefing for the practice team
- Distribution of patient feedback questionnaire to be used for service improvement, at the beginning and end of the process.
- Involvement in practice based training sessions
- Practice planning for project implementation and selection of target patient groups
- Action and learning using the seven principles during normal consultation processes
- Review and on-going planning with primary health care team

# New Media Technology...

## ...NHS Great Yarmouth and Waveney Story

The "Living Life" website brings together a wealth of information about a huge range of long-term conditions, along with details about where to go locally for help and support. It also gives hints and tips on the best ways that patients can help themselves, along with an interactive forum where people can exchange ideas and offer each other support.

Health chiefs at NHS GYW together with Dr Vince Forte and his team at the Central Surgery in Gorleston developed the website for the large number of people with long-term conditions living in the area.

David Edwards, Chairman of NHS Great Yarmouth and Waveney, said: "People can use the site to find local support groups, get tips on how best to help themselves and share their thoughts and experiences with others so they can move towards self-managing their condition as much as possible.

We hope it will put patients and their carers right at the heart of the services they receive and prove an extremely useful tool for those wanting help or advice."

The website also features a password-protected area where patients can keep an electronic diary of their personal health plan, a new initiative from the Department of Health. It is hoped that GPs and other health professionals will recommend the website to their patients as a good port of call for information or advice. Also to be rolled out from December, initially to diabetic patients and some people with heart failure, is a new Personal Health Plan.

The plan, which is a hard backed A5 folder, contains useful sheets to log medical history and information about an individual which they can take to healthcare professionals. People who have diabetes or some people who have suffered heart failure will be invited by their GP to use the personal health plans (PHP) when the project is rolled out initially in December. It will be offered to all patients with long term conditions by March 2011.

**To view the website, visit [www.livinglife.gyw.nhs.uk](http://www.livinglife.gyw.nhs.uk)**

# Launching the Programme...

## ...an NHS Norfolk Story

NHS Norfolk is at the beginning of a procurement process that aims to deliver Self Management services for the population of NHS Norfolk. A launching event of the procurement process was held on 11 November and outlined to potential providers what self management services NHS Norfolk wanted to commission to help people manage their Long Term Condition.

### The half day event covered how to:

- Help to better understand our priorities for the commissioning of self-management services
- Make clear the process, timescales and criteria for putting in bids
- Provide service specifications, which will set out what we expect to be provided for people with a Long Term Condition in each disease group
- Provide an opportunity to discuss innovative ideas with Commissioners and potential partners
- Provide the opportunity for providers or potential lead contractors to find out what already exists in Norfolk and identify any opportunities for partnership working.

Don't be afraid to take one large step, because you can't cross a chasm in two small leaps.