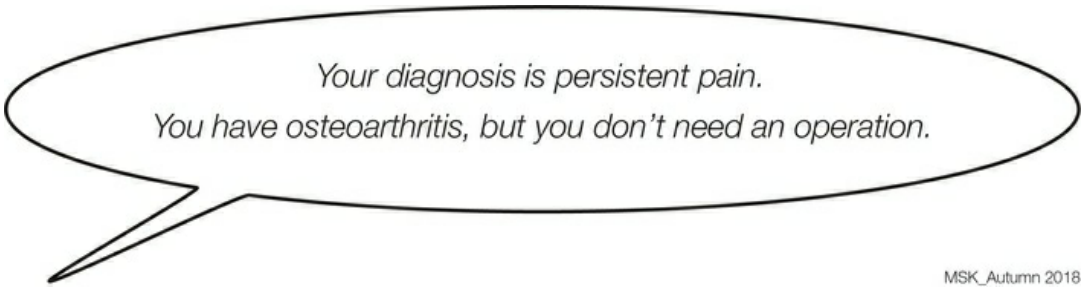
Self-care and self-management: introduction



Now what?

We all know that we should be encouraging patients with long-term conditions to 'self-manage' or 'self-care' – these have been some of the health buzz words of the decade, and are seen by the Government as the 'holy-grail' of reducing demand on the NHS.

And yet, for me, there is a real knowledge gap between knowing I should be doing this and knowing how to do this in the best way. Self-care is not the same as 'no care'.

When we first ran the MSK and Chronic Pain course, we were approached by a fantastic GP and pain rehabilitation specialist, Dr Frances Cole. She has developed a comprehensive array of resources for primary care professionals and patients, and agreed that we could use these resources to develop some teaching material around self-management.

While in this article we are talking about persistent pain, these skills and tools are transferable to any long-term condition, and we hope you find them useful.

Resources used to develop this article include:

An introduction to living well with pain (Dr Frances Cole, Robinson, 2017)

Promoting optimal self-care: consultation techniques that improve quality of life for patients and clinicians (NHS publications 2005)

Overcoming chronic pain: a self-help guide using cognitive behavioral techniques (Cole, Macdonald, Carus and Howden-Leach: Robinson 2010)

What is self-care or self-management?

Well, it isn't the same thing as 'no care'!

The vast majority of the UK population who are not hospitalised or in a care home are self-caring for their health pretty much all of the time – but they are very different in their effectiveness and ability to do this.

- The WHO definition of **self-care** refers to activities that individuals, families and communities undertake to enhance their health, prevent disease and limit illness/restore health.
- **Self-management** relates specifically to an individual with a long-term condition and their ability to manage the consequences of living with that long-term condition.

The terms are used interchangeably in these articles.

Our actions as health professionals can increase or decrease an individual's ability to care for themselves. Here, we look at factors that can increase or decrease an individual's ability to self-care.

Increase ability to self-care	May decrease ability to self-care
• Supportive, non-judgmental consultation style. • Coaching interviewing style that promotes change. • Understanding the patient's psychosocial framework – what this condition means to them. • Balancing pathological explanations with helpful information, e.g. keeping your muscles strong and keeping your body moving will actually help to support your joints. • Active treatments.	• Being on a waiting list. • Biomedical/pathological explanations of long-term conditions, e.g. 'wear and tear' arthritis. • Passive treatments. • A belief that medicine still has 'more to offer'.

Does self-care work?

Yes.

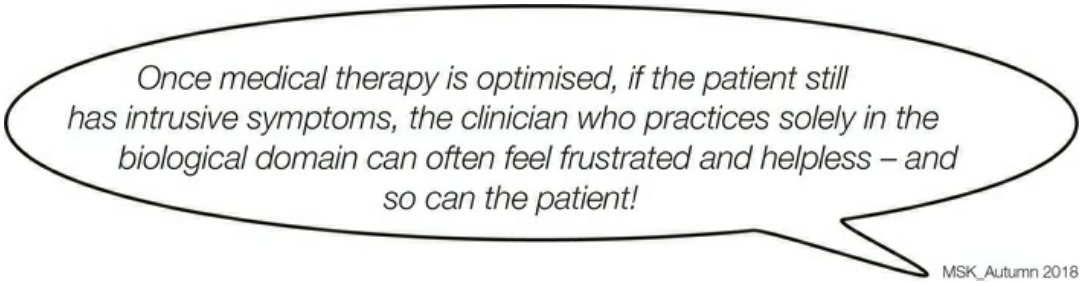
Effective self-care has been demonstrated to:

- Improve quality of life of patients.
- Improve satisfaction with the quality of medical care.
- Reduce the need for hospital admission.
- **Reduce the need for repeat visits to primary care (yay!).**
- Increase clinician enjoyment and job satisfaction.

In the current NHS climate, this can only be a good thing! Optimising the ability of our population to self-manage their conditions should be a core skill of all health professionals.

And yet it is not incentivised by QoF and receives small priority in our training and education. It gets pushed out by other agendas.

Who should could teach self-management?



All healthcare professionals can develop the skills to do this. It is not something that can only be done by GPs and, in fact, our nursing team and clinical pharmacists may be excellent resources in supporting our patients in this respect!

When it comes to persistent pain, how patients access this will depend on local resources.

Interestingly, much of the research on self-management programmes has been done on small groups where the leader is often a peer with a long-term condition (not a health professional) who has received training and works with a small group to build their skills to self-manage.

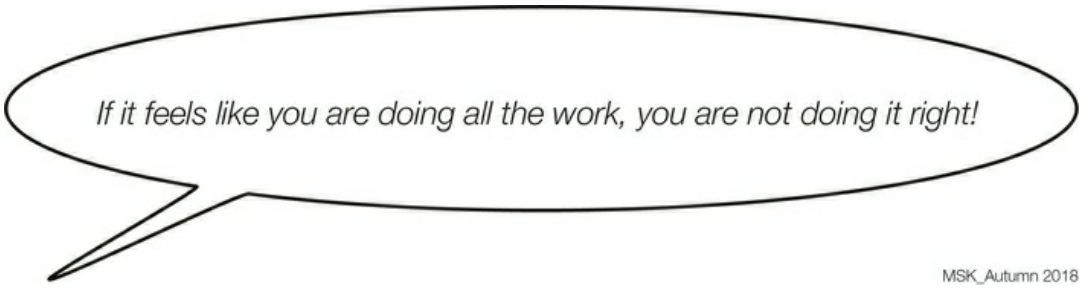
This is based on the theory of self-efficacy. These groups were being rolled out across the UK under Tony Blair's administration as part of the 'Expert patient programme' but evidence of impact was mixed, and they often attracted fairly well-educated and motivated patients (the inverse care law in action). They are still functioning in some parts of the country.

You may have access to persistent pain self-management programmes through your local pain clinic services, MSK hub or IAPT. If so, you can make use of these.

If not, we may consider looking at coaching our patients in some of these skills in primary care…

I know, I hear you, it's ….

A question of time



We have a lot to achieve in our short primary care consultations. It can feel overwhelming to be asked to do something that seems to be new.

But ask yourself:

- Are you seeing these patients anyway?
- Are you having multiple consultations about medication…and medication side-effects…and sick notes…and requests for more

investigations?

Patients with persistent pain use, on average, 3 hours of healthcare time over each 12-month period – that may be in primary care or elsewhere.

Persistent pain, for most, is a lifelong condition – exactly like diabetes or ischemic heart disease. It isn't going anywhere so we don't have to achieve everything in 10 minutes. What we do need is a range of strategies to use.

The purpose of this article is to give you the practical tools you need to change the dialogue and use those consultations more productively. This article may be helpful for all clinical members of the primary care team.

Introducing the idea of self-care to patients

This can be difficult for us and patients. Our medical model is that we should be able to 'do something' for the patient, and the patient can perceive that the idea of self-care is suggesting they are 'wasting our time' or it is 'all in their heads'.

A key message is that **all medical interventions should support self-care**. But if we are introducing this idea when a person is already some way along their journey with persistent pain or another long-term condition, there is evidence that, to help them to embrace self-care, we need to ensure:

- Evidence-based medical interventions have been discussed and offered, optimising the medical condition (this is the clinical content of this handbook!).
- The likely outcomes and limitations of medical interventions have been discussed.
- There has been a frank discussion that, for an optimal outcome, the patient must take some responsibility for managing their condition and their life.

And then we need to:

- **STOP offering medical interventions!**

We need to have a change of mindset, and move from 'telling' mode to 'coaching' mode.

The core principles of coaching involve:

- Listening.
- Raising **awareness**.
- Getting the 'coachee' to generate options.
- Leaving the **choice** and **responsibility** about actions firmly with the individual.

What if they don't want to self-care?

Self-care is a change. A big part of our job as primary care professionals is 'change management'. Being ready to make lifestyle change and take responsibility for our health can be difficult for patients (and health professionals). Change is a cyclical process that can be illustrated like this:

What about if they are not ready or willing?

Here are some ideas that might help – because all three factors have to be present before we can effectively move on to the next steps.

	Barriers	Possible solutions
Not READY?	A belief that medicine has something to offer in terms of: • Tests. • Treatments. A belief that symptoms are the body's way of telling us to avoid activity.	• Summarising what has been done so far and what it means. • Clear explanations of what is and is not possible. • An explanation that their medical condition is optimally managed. • Challenging beliefs and expectations. • Using helpful and informative explanations of conditions rather than pathological explanations.
Not WILLING?	There may not be sufficient discrepancy between what is happening at the moment and what this particular individual wishes was happening in terms of their values and personal situation. There may be collusion or value in occupying the sick role.	• Try exploring this and extrapolating to the future: "Is life just as you would like it or are their things you would like to change?" • Try facilitating a discussion that imagines different futures. • Gentle confrontation may be needed.
Not ABLE?	Lack of 'general efficacy', i.e. a belief that change won't help or make a difference. Lack of 'self-efficacy' or self-belief/confidence.	• This involves sharing knowledge and information about why change will help in their specific situation. • Try considering other times where they have been successful in achieving goals. • Break the goals down into smaller, more manageable tasks: "What is the smallest thing you can do to get you a little nearer to where you want to be".

What skills will help?

For this part of the cycle, motivational interviewing techniques may help. If this is a new concept for you and something you have not yet had the chance to practice, have a look at the next article, *Promoting lifestyle behaviour change.*

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- Promoting self-care is essential for optimal management of all long-term conditions.
- It is a win-win, improving patients' quality of life and reducing demand.
- It requires skilful communication and, for some of us, these skills may be new.
- Things we do can actually reduce a patient's likelihood of self-caring.
- When medical treatment is optimised, STOP offering tests and interventions, and move on.

Are these communication skills new for your tool box? Explore this chapter further.
Identify 2 or 3 of your patients with persistent pain – look at their pain journey, their history of investigations, etc. Is there a clear narrative of promoting self-care? Is there a clear point where medical treatment was optimised and a decision made to move on to other parts of the agenda?
Consider trying out some of these techniques with one of your patients.

Look at the 'Shifting the conversation' resources on Live Well with Pain:
https://livewellwithpain.co.uk/resources/shifting-the-conversation/