Supporting people to self-manage

NHS
Education
for
Scotland

Education and training for healthcare practitioners:
A review of the evidence to promote discussion

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Contents

Executive Summary

NHS Education for Scotland (NES) decided in early 2012 to conduct a review of the literature associated with the education and training of healthcare practitioners who support people to self-manage long term conditions (LTCs). The intention of the literature review was not to 'go back to the beginning' but rather to stimulate discussion around 'where to now'.

This followed the publication of a report by the Health Foundation (2011), which noted that there is still a long way to go before we understand the education and support healthcare professionals need to support people to self-manage. This is consistent with evidence that healthcare practitioners are still not necessarily well equipped to promote self-management given a relative lack of training in self-management approaches (Lake et al. 2010).

It is acknowledged that simply providing education alone for healthcare practitioners is not likely to bring about the transformational change required for self-management to become truly embedded across the health system. But it is a critical part of the jigsaw, therefore it is important to gain a more comprehensive understanding of what education is required and how it should be provided.

Key messages

- **No 'one size fits all'** – there is no one education solution to suit all groups of healthcare practitioners or all clinical areas. However there are a number of common areas related to education for healthcare practitioners to support self-management. Education needs to be relevant to the healthcare context.

- **Person centred approach** – supporting self-management is a person centred approach and by definition, communication skills are central to its implementation. People with LTCs want to involve themselves (or their representatives) in the development and evaluation of self-management support (SMS) training for healthcare professionals. This is consistent with the view that self-management education can emerge from a co-creation paradigm rather than having an external expert or didactic frame.

- **Specific skills and knowledge** – given the multiple theories associated with SMS practitioners would benefit from a comprehensive set of skills rather than focusing exclusively on one model.

- **Support for learning** – practitioners need continued support to enable change in practice, and to maintain this change because it is easy to revert to business as usual. This requires a focus on integrated behaviour change rather than the simple acquisition of skills.

- **Organisation processes and systems** – practitioners need to be able to influence organisation processes and procedures, as these are some of the things that can act as either enablers or challenges to integrated self-management support. Learning therefore needs to be part of a wider process of change rather than stand alone.

- **Dominant ways of thinking and doing** – it is vital that education addresses the attitudes, beliefs and values of healthcare practitioners in relation to self-management. These can have a significant impact on i) how the SMS they provide is experienced by people, ii) their own engagement with education related to SMS and iii) their capacity to change practice. Self-management can be seen as being about instilling a new way of practising which may be at odds with practitioners preferred approach and that which they feel comfortable with. The wide definitions and beliefs about what constitutes self-management mean that practitioners can believe 'we already do that' or it can be possible for a practitioner to believe that their practices are fully supporting and enabling self-management without this being fully reflected in their behaviours and actions. Barriers to change can be associated with lack of time and pressure to conform to traditional bio-medical aspects of the consultation.

This literature review does not offer a simple education solution but raises a number of issues or points intended to inform further discussion. Appraising the evidence has increased our intelligence and understanding of this area of practice, and NES are keen to continue to work in partnership with partners in NHS boards, the third sector, education providers and other stakeholders to take forward this critical agenda.

Introduction

In 2011 the Health Foundation produced a review of the evidence looking at whether it is worthwhile to support people to self-manage. The report looked at more than five hundred pieces of evidence and concluded that 'self-management works'. Specifically, that proactive, behaviourally focused self-management support (SMS) can have a positive impact on symptoms, usage of healthcare service and quality of life.

However the report also noted issues that required more attention; and one of these was our limited knowledge about which strategies work best to help clinicians support people to self manage. This is consistent with evidence that healthcare practitioners are still not necessarily well equipped to promote self-management given a relative lack of training in self-management approaches (Lake et al. 2010).

Gaining a more comprehensive picture of what works best to support clinicians requires intelligence from a range of sources, including service improvement initiatives, evaluation of education and development activities and from personal experiences. In light of this NHS Education for

Scotland (NES) decided in early 2012 to conduct a review of the literature associated with the education and training of healthcare practitioners who support people to self-manage long term conditions (LTCs). Its purpose is twofold:

1. It contributes to our understanding of what supports practitioners.

2. It is a resource for ourselves and other stakeholders who provide staff education, support and development opportunities associated with self-management. As such, it can be used to 'sense check' current provision and to inform future developments.

In relation to point 2 above we recognise the wide range of education and development opportunities that currently exist and extensive work that has, and is, being done across different sectors to support staff. **The intention of the literature review is therefore not to 'go back to the beginning' but rather to stimulate discussion around 'where to now'.**
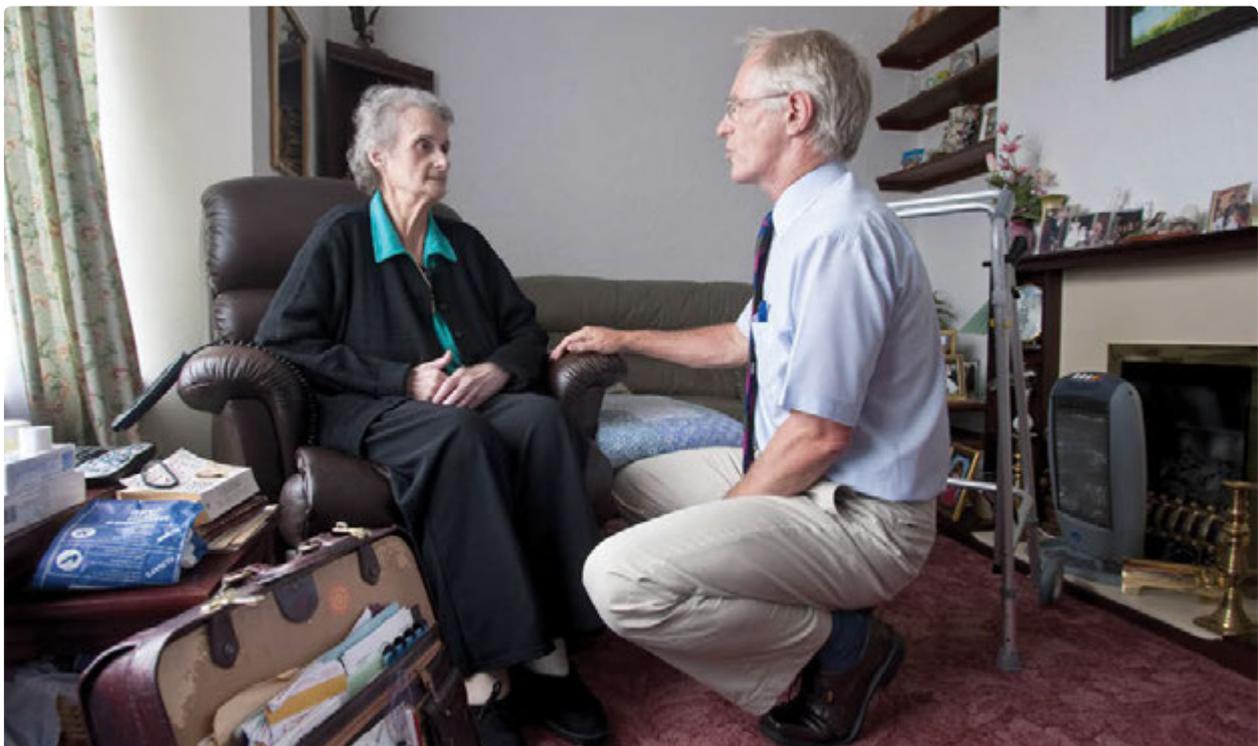
About the Literature Review

The broad aim was to review the recent literature relating to education, training and support necessary to optimise healthcare practitioners' (some journals may refer to clinicians) attitudes, skills and behaviours in order for them to support people with long term conditions to self-manage (or self-care).

The following questions formed the basis of the literature review and the findings in response to these are presented in sequential order.

1. What knowledge and skills do healthcare practitioners need to be able to provide effective self-management support?

2. How is training and information on SMS for healthcare practitioners currently accessed and delivered and how effective is it?

3. What barriers and enablers to SMS training and education are identified in the literature?

4. What gaps in SMS training and education are identified in the literature?

Scope of the review

- The majority of the literature located was from the UK, USA and Australia. It covers the range of healthcare professionals but in the main concentrates on General Practitioners (GPs), nurses and therapists. This is because the primary care workforce is seen as being at the heart of helping patients to self-manage LTCs. Self-management support has been called the "core business" of the primary care workforce (Lawn 2007).

- In the context of this review "healthcare practitioners" covers registered practitioners working in the health sector rather than those in any other sectors. This is not to diminish the contribution of those who work outside the health sector but the intention in this first instance is to review the evidence relating to those in the health sector. In this respect healthcare professionals are primarily registered practitioners. However the literature also makes references to pre-registration (under-graduate) staff and un-registered staff and these are included for completeness.

- This document is based on a narrative literature review. This format was used because the aim was to provide an overview of the subject matter rather than a complete, in-depth analysis. The process of carrying out the literature review is outlined in Appendix 1. The literature search for the review was limited to the year 2000 onwards.

- The assumption that supporting self-management is beneficial is taken as read given that a detailed discussion of the merits of self-management is beyond the scope of this review.

Limitations of the review

- The literature searches were not carried out in a systematic manner and therefore cannot claim to be comprehensive. However given that the rationale for the literature searches was to inform discussion and these searches were supplemented by literature located from a variety of other sources the method employed can justifiably claim to be commensurate with its aim of informing and generating discussion.

What is Self-Management

"Self-management is a person-centred approach in which the individual is empowered and has ownership over the management of their life and conditions"

Long-Term Conditions Alliance Scotland (2008)

There are many different ways of defining or understanding self-management but regardless of the language or description used there are some common themes and principles that underpin most definitions. These are briefly noted here because they place the skills, attitudes and behaviours required by healthcare practitioners in context.

The tasks associated with self-management for the individual include developing knowledge of the conditions and treatment; management of own medication; managing the effects of illness on physical, emotional and social role function; reducing health risks; preventative maintenance and working collaboratively with health professionals (Battersby et al. 2010). In addition, for self-management to be effective there must be a partnership between the patient, their family and healthcare providers.

In terms of healthcare professional's input into the process this is termed as self-management support (SMS) and put simply "includes actions by healthcare providers (formal and informal) that assist self-management". The application of self-management for LTCs has been operationalised in the form of a number of models including the Stanford Model for patients (Lorig et al. 1985) and Flinders model for clinicians (Regan-Smith et al. 2006).

"Gaun Yersel!" The Self-management Strategy for Long Term Conditions in Scotland (Long Term Conditions Alliance Scotland, 2008) outlines a number of key principles - firstly the system should "be accountable to me and value my experience". Secondly "I am a whole person and this is for the whole of my life" recognises that continuing support will be required to improve a person's physical, emotional, social and spiritual wellbeing. Thirdly a partnership approach is emphasised in the principle that "self-management is not a replacement for services, Gaun Yersel doesn't mean going it alone". Similarly the principle "I am the leading partner in the management of my health" signifies that the individual has a prominent role to play in determining their care. Finally "clear information helps me make decisions that are right for me" acknowledges the crucial need for individuals to be fully informed if they are to participate fully in the self-management process.

Findings

The broad view

The literature highlights strong correlation between person centred care and supported self-management, with person centredness being at the centre of the health professional's role in supporting people to self-manage (Little et al., 2001). This assumes that the health professional and person will be equal partners in the decision making process. A key requirement of this shift in provision is the adoption of self-management models where individuals are encouraged to take active responsibility for their condition(s) and have an input into their own care (Regan-Smith et al. 2006).

As previously noted there is some evidence that healthcare practitioners are still not necessarily well equipped to promote self-management (Lake et al. 2010). For example, a major Australian research project (Battersby et al. 2008), (Lawn and Battersby 2009) undertook a training needs analysis of primary healthcare professionals in SMS. It identified the following challenges:

- With the exception of health professionals who are specifically trained or currently working in SMS, there was an overall lack of understanding, competence and practice of SMS among primary healthcare professionals.

- Primary healthcare workers consistently rated translation of training into practice as a major problem with training they received.

- The primary healthcare workforce appears not to have the full set of skills needed to support consumers' behaviour change.

- A systemic approach is required to implement SMS training models, facilitated by organisational support, and accreditation from professional bodies, as key elements for successful transference of training to practice.

More recently The Health Foundation (2011) in their review on the value of self-management made a number of observations on the training of healthcare professionals. These headline observations relating to training and education of healthcare professionals in SMS are replicated here to set the background and to place the findings from our review in context:

- There is still a long way to go before we understand the education and support necessary to optimise clinicians' attitudes, skills and behaviours towards self-management.

- Some suggest that training strategies need to account for practitioner's stage of change as well as that of patients.

- The attitudes and skills of healthcare providers can have a significant effect on the extent to which people feel engaged and supported and this is an area in need of further exploration.

- A number of strategies have been tested to improve clinician communication strategies and help professionals support self-management. However differing results from these suggest that knowledge is limited about the best strategies to help clinicians support self-management.

- There may be work to do to educate clinicians about the value and scope of supporting self-management and the skills they need to achieve this.

The above can be considered a useful reference point in considering the following evidence gleaned from the literature.

Question 1: What knowledge and skills do healthcare professionals need to be able to provide effective self-management support?

1.1 Core principles underpinning the content of training

A number of principles have been identified (table 1) which under-pin the content of training required to support self-management; they encompass both skills acquisition and system's knowledge.

Table 1 – Principles underpinning the content of SMS training

7 core principles for operationalising self-management support (Skills for Care and Skills for Health, 2008)	12 evidenced based principles which have been found to improve self-management support (Battersby et al., 2010)
• ensure that people are able to make informed choices to manage their self-care needs; • communicate effectively to enable people to assess their needs and develop and gain confidence to self-care; • support and enable people to access appropriate information to manage their self-care needs; • support and enable people to develop skills in self-care; support and enable people to use technology to support self-care; • advise people 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.	• employing targeted assessments • the provision of information for shared decision making • use of a non-judgemental approach • collaborative priority and goal setting • collaborative problem solving • self-management support from diverse providers • self-management interventions delivered in diverse formats • enhancing patient self-efficacy • ensuring active follow-up • employing guideline-based case management for selected patients • linking to evidence-based community programmes • multi-faceted interventions are more effective than single-component interventions. The rationale for the evidenced principles is provided in Appendix 2.

1.2 Competencies, skills and attitudes required by healthcare practitioners

The literature identifies a range of competencies, skills and knowledge that primary healthcare professionals will need to integrate into their practice to assist individuals to self-manage (Lawn 2007). At an individual practitioner's level, aside from the given of clinical knowledge, these are:

- the way they interact with patients
- how they work with their colleagues in the primary care sector
- the knowledge and skills to reconfigure the way they work to accommodate a self-management approach
- the awareness of the barriers they may come up against in implementing systems change
- the knowledge of potential solutions to counter-act these obstacles

The way practitioners interact with their patients becomes of paramount importance in a person centred model of healthcare delivery. By definition communication skills are central to implementing this person centred approach and are integral to its key components such as the exploration of experience, understanding the whole person, finding common ground, health promotion, and enhancing the relationship to encompass caring and power sharing (Little et al. 2001). The importance of developing communication skills in SMS across a range of interactions is illustrated in the literature. These include counselling skills (King et al. 2002) and consultation styles (de Ridder et al. 2007).

In terms of the specific SMS skills required by healthcare practitioners Battersby et al. (2008) identify the following skills in three distinct areas: person centred care, behaviour change and systems.

Table 2 – SMS skills required by healthcare professionals

General Person Centred Skills	Behaviour Change Skills	Organisational/System Skills
Health promotion approaches	Models of health behaviour change	Working in multi-disciplinary teams
Assessment of health risk factors	Motivational interviewing	Electronic (or other) recall systems
Communication skills	Collaborative problem definition	Organisational change techniques
Assessment of self-management capacity	Goal setting	Evidence based guidelines
Collaborative care planning	Structured problem solving	Conducting practice based research/quality improvement framework
Use of peer support		Awareness of community resources
Cultural awareness/ interpreter service utilisation		
Psychosocial/life skills		

In terms of developing skills and competencies Lawn (2007) identifies a number of areas where up skilling is required. The areas identified are described in full in appendix 3. Those most relevant to the education of healthcare professionals include an imperative to make sure that their training places patients at the centre of a collaborative care process. This involves ensuring that the focus on patients is inclusive, participative and takes account of their quality of life and well-being. Similarly healthcare practitioners must be schooled in techniques which effect behaviour change. This will involve an understanding of self-efficacy, motivation, stages of change, the role of peers, and goal setting. Equally there is a need to equip practitioners with skills in supporting those with particular needs such as young people and those with mental illness or drug addictions.

1.3 Profession specific training and education needs

Lawn (2007) examined the individual professions who make up the primary healthcare workforce in terms of their strengths and weaknesses in providing SMS. The collective overview by profession emphasises the contributions that each can make to multi-disciplinary team working in this area and also the need to draw upon the team's collective knowledge and skills when individual professions may be less well equipped than others in particular areas.

In terms of the role of doctors the literature notes the traditional emphasis on the medical model of consultation which is concerned with treatment, prescription and administration of medicines and the mechanisms of disease. This is not necessarily congruent with the person centred approach adopted in SMS. Another challenge highlighted in the literature in providing SMS is effective communication between doctor and patient. Doctors may encounter a host of challenges in this interaction including those related to health literacy.

Kennedy et al. (2010) note the workload pressures on doctors which constrain their ability to adopt self-management approaches, notably in the time it takes to consult in a truly person centred way. This prompts them to consider the "division of labour" in a general practice and who in the practice is most suited to promote self-management to patients with the answer being practice nurses in many cases. An increased role for practice nurses may be a solution as they are ideally placed to work closely to guidelines and targets for LTC management. Indeed Lawn (2007) notes the contribution that practice nurses can make to SMS which has been demonstrated in studies which show that their involvement can improve outcomes in chronic disease.

Similarly there is a key role for allied health professionals (physiotherapists, occupational therapists), psychologists and pharmacists to play in supporting SMS (Lawn 2007).

Occupational therapy contributes effectively to SMS as it embodies many of the principles required for this in its own practice e.g. self-management and patient-centred collaborative care. Equally physiotherapy routinely incorporates many of the practices embraced in SMS, for example the use of active adaptive coping and self-efficacy enhancing strategies, supported goal setting and active patient involvement.

Psychologists are recognised in the literature as being key players in SMS through the interventions that they deliver. Examples of these include compliance therapy, supportive therapy, psychoeducation and Cognitive Behavioural Therapy (CBT). Similarly pharmacists actively use health plans, including patient self-management education, in the management of diabetes, asthma and congestive heart failure. In addition the literature recounts pharmacists employing self-monitoring, patient education and self-management interventions in treating hypertension.

1.4 Preparing healthcare practitioners at pre-registration level

There is an acknowledgement in the literature of a double challenge in educating healthcare professionals to provide SMS. Firstly, the tailoring of training for a section of established practitioners who have a particular approach to engaging with patients which does not necessarily fit with a person centred approach. For example, those schooled in the traditional bio-medical model of consultation. In effect the challenge is instilling a new way of practising which may be at odds with their preferred approach and what they feel comfortable with.

The other challenge relates to educating the next generation of healthcare professionals as they undertake their pre-registration (undergraduate) training. In effect equipping them with the skills and knowledge they need to provide SMS as they become qualified practitioners. There is some indication of variations in undergraduate curriculums being geared up for teaching SMS skills. For example Pols et al. (2009) consider the need to introduce particular competencies for medical students in the field of self-management support. Areas identified include skills in team working, care planning, lifestyle behaviour change and risk factor reduction. In contrast allied health profession pre-registration training programmes (e.g. occupational therapy, physiotherapy) contain many of the core elements vital to SMS e.g. design of collaborative care plans, goal setting, structured problem solving, working in multi-disciplinary teams, etc.

1.5 The patient's perspective

Given the adoption of person centred care as being core to self-management it is important to consider the views of service users on their experience of self-management support and their perceptions of healthcare professionals' training needs in this area. Lawn et al. (2009) investigated consumers' perspectives of the skills required by healthcare professionals in a small scale study which sought the views of service users, carers and key informants from major consumer and advocacy groups. This particular study was a component of the larger scale study undertaken by Battersby et al. (2008).

"A key view of the consumers was the need to involve themselves or their representatives in the development and evaluation of SMS training for healthcare professionals."

Lawn et al. (2009)

At a micro level nineteen specific SMS skills required by healthcare professionals were identified by consumers and mapped against the skills identified in the larger scale study. These nineteen skills were grouped into the following broad areas:

- communication skills, including listening and asking questions about the consumer's experience of their chronic conditions and management

- knowledge of community resources available to support the person and their carers

- identification of consumers' strengths and current capacities

- collaborative care with other health professionals, consumers and carers

- psychosocial skills to understand the impact of chronic conditions from the person's perspective

As well as consumers it is also important to consider the input of practitioners themselves in the development of SMS training. This was illustrated by a study which compared the learning needs of nurses delivering SMS for those with type 2 diabetes and those identified by educators tasked with providing the appropriate education (Sen 2005). In this case significant differences were found between the learning needs identified by the practitioners and educators.

Question 2: How is training and information currently accessed and delivered and how effective is it?

2.1 The provision of and delivery of SMS training

The literature identifies a wide range of training providers and delivery formats (Lawn 2007). Training is provided by professional bodies, commercial providers, in-house staff development, the voluntary sector and academic institutions. In terms of formats these include post-graduate courses, workshops, community education forums, general and discipline specific seminars, online modules and as continuing professional development (CPD) as part of the membership of specific professions.

The emergence of the potential of electronic learning is highlighted by Bowler (2010) who piloted and evaluated an e-learning tool. The objective of the tool was to highlight to healthcare staff the importance of self-care and outline the activities that are required to support people to self-manage their long-term conditions. A cartoon character named Stan was created to guide staff through the Skills, Tools, Advice and Networks that would empower them to deliver self-management support. The tool was piloted with 31 community matrons and an audit of documentation post-learning revealed a more standardised approach to care planning, evaluation and re-assessment which implied that practice had improved as a result of the learning intervention.

The SMS training reviewed was typically found to contain the following type of domains (Lawn 2007): evidence base and rationale; theoretical principles; practice issues; demonstrations and role play; practice sessions with feedback using 'real-life' volunteers; discussions of application of learning to clinical or practice experience.

In many areas of health, practitioners traditionally learned in a uni-disciplinary manner, particularly at pre-registration level. However this has changed considerably in more recent years as inter-professional (or multi-disciplinary) training becomes more common. The rationale behind this is that healthcare practitioners who learn together will then work together more effectively. This is particularly relevant to supporting people to self-manage given the emphasis placed on collaborative approaches and the importance of knowing about and valuing the contribution of a range of people. The health and social care integration agenda may increasingly allow for education and training to be provided across sectors. Alongside this, the voluntary sector is increasingly recognised by the health sector as both a key provider of education and an environment where practitioners can learn about self-management support e.g. through practice placements for pre-registration students.

Battersby et al. (2008) carried out an audit of training in Australia which revealed that universities provided the majority of SMS training for healthcare professionals and workshops were the most frequently used format. The integration of skills/components and translation of knowledge and skills into practice was found to be uncertain. Urban areas had better access to training which is often expensive to undertake. Finally in terms of assessing the quality of training, it was observed that better evaluation was required.

2.2 Acquisition of SMS knowledge

In addition to training, healthcare professionals acquire knowledge through a variety of mediums (Lawn 2007). Typically these include:

- Evidence-based reviews, peer and non-peer reviewed journals, reports and other written materials.

- Through newsletters, magazines, checklists, websites.

- Guidelines and tools developed specifically for the primary care workforce.

- Word-of-mouth, community network communication (e.g. communities of practice), local expertise, local research and projects, in-house information sharing.

As previously noted, opportunity for the acquisition of SMS knowledge and attitudes are also created through partnership working with the voluntary sector. This can be both formal through arrangements such as student practice placements and partnership projects, and a more informal process of influence and learning through increased exposure to each others thinking, practices and philosophies.

The dissemination of guidelines and their adoption into practice raises particular challenges. These include the process of interpreting written evidence into action,

prioritising recommendations, ensuring all members of the multi-disciplinary team take part and the preparedness of health professionals (West et al. 2002).

Given the variety of provision of training and learning formats Lawn (2007) notes that the preferred delivery option for any individual or group will depend on a number of factors, for example the location of the training, available time and resources, funding constraints, organisational structure, level of management support, population served, and learning style of the individual (e.g. preference for self-directed learning) among others.

For example, Lozano et al. (2004) conducted a major multi-site clinical randomised controlled trial assessing the value of three different strategies for asthma management of children. One of the strategies included training a planned care intervention which involved asthma nurses being trained in national asthma guidelines and self-management support techniques (the application of medication adherence, technical skills, etc using problem solving and motivational techniques). The planned care approach was also supported by the training of a peer leader in their practice. The trial revealed that the planned care approach (supported by the peer leader intervention) resulted in the reduction of asthma symptom days by 12% or the equivalent of 13 days a year.
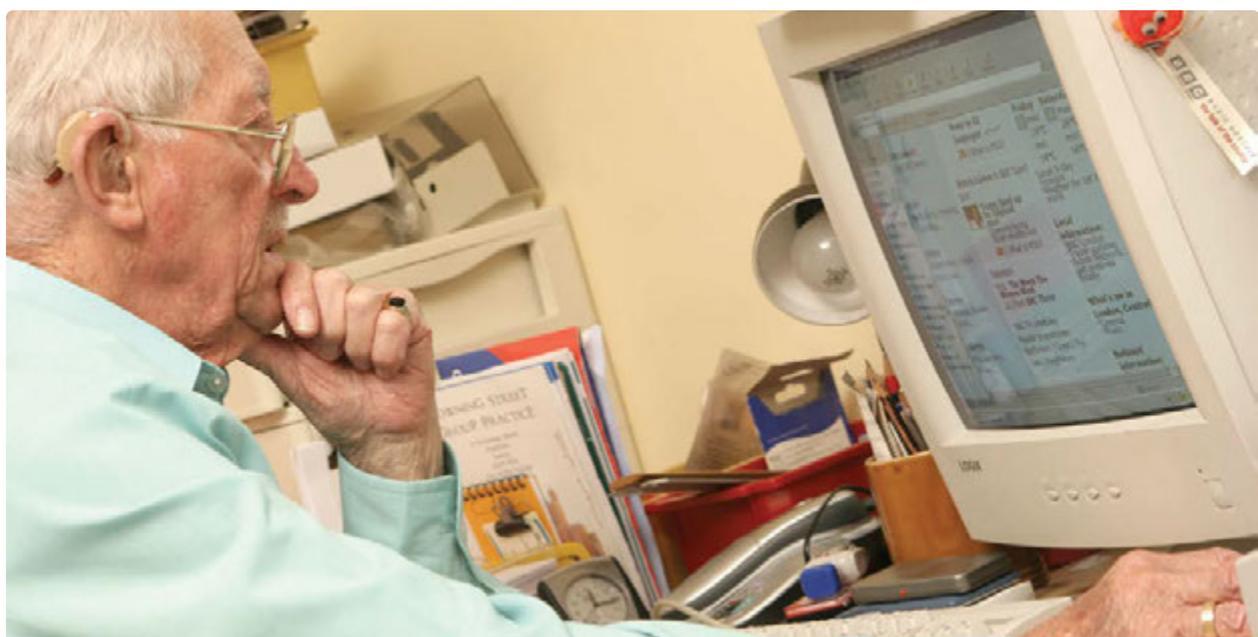
Question 3: What barriers to SMS training and education are identified in the literature?

Even given the provision of training and learning materials for self-management support a number of barriers to their take-up and adoption is identified in the literature. Lawn (2007) identifies barriers at all levels relevant to the implementation of SMS, namely at macro level (healthcare policy and infra-structure), meso level (organisational and practice) and micro level (individual practitioner).

While identifying the SMS training needs of primary care healthcare professionals Lawn (2007) notes the wide range of factors which can influence the actual delivery of education. These include macro considerations such as population profiles, government policies, healthcare trends, organisational needs and professional requirements. Allied to these considerations are a number of organisational opportunities and challenges which play into the mix. An organisation's vision, values and strategic decisions which shape its structure and culture may in turn influence its attitude toward preparing its workforce educationally. Similarly service objectives may be another factor.

A number of case studies illustrate the barriers that have been experienced by those conducting SMS training and then practitioners attempting to implement this approach in practice.

3.1 Conducting training

Doherty et al. (2000) piloted a multi-disciplinary training programme in change counselling for a diabetes team. The main challenge surrounding the training for staff was uncertainty about the value of the time commitment required to undertake this as it amounted to 40 hours. Similarly skill acquisition was an issue with participants finding it testing to adapt their normal practice of informing and advising to eliciting thoughts and feelings and inputting into patient generated plans. However most of the necessary change counselling skills had been learned at the end of the six month training period. The most difficult skills to acquire were reported to be those which deal with patient's general feelings. The six month follow-up evaluation revealed a decrease in skill application which suggested a need for ongoing support and training perhaps in the form of mentoring from senior staff.

Particular issues with running multi-disciplinary training are reported by Kennedy et al. (2010) who evaluated a course in SMS for general practices. Practical difficulties were encountered in ensuring that all members of the practice could attend the two group training sessions. Further the content of the training was not deemed universally relevant for all staff e.g. administration staff. This was subsequently remedied by changing the format of the training to three sessions and tailoring them to the appropriate audience e.g. one was for clinicians only.

3.2 Integration of SMS following training

Kennedy et al. (2005) report on the training of gastroenterology consultants in person centred consulting in a randomised controlled trial helping patients with irritable bowel disease to self-manage their condition. The project was relatively successful in training consultants in the techniques of person centred consulting as measured by patients feeling more confident and able to self-manage their condition following a consultation. However the patients reported in the evaluation that the self-management plans in the consultation tended to concentrate purely on medication for relapses. Also the consultants struggled to put this type of consultation into practice due to the time that had to be devoted to this person centred approach. This led the researchers to conclude that despite the training the consultations were still very much medically orientated and thus not truly person centred.

This report is a good example of the well recognised challenge of integrating new learning into daily practice, particularly the issue of slipping back into 'business as usual' if people are not supported to maintain the new behaviours. Arguably this is of particular relevance to self-management where it can be difficult for a practitioner to get an objective perspective on their self- management practice. Therefore it is possible for a practitioner to believe that their practices are fully supporting and enabling self-management without this being fully reflected in their behaviours and actions.

Doherty et al (2000) evaluated the application of SMS into practice following training for a diabetes team and revealed a number of issues. The examination of video tapes of consultations showed that change counselling was not being routinely used and staff were finding it difficult to recruit and retain patients for a series of consultations to support self-management. These issues were further investigated in staff and patients and revealed a number of barriers to implementing self-management support in practice. Patients indicated that they did not want to think about diabetes, finding time to address it was difficult as were the practicalities of keeping appointments. Staff barriers were time, a lack of competence in methods and the importance of other clinical matters.

A combination of these barriers was characterised as staff "reverting to type" and not utilising their behaviour change skills when they were placed under pressure in the clinical environment. The barriers to implementing behaviour change techniques were further reinforced by service challenges, predominately again time and the pressure to conform to traditional bio-medical aspects of the consultation. This prompts the authors to suggest that alternative approaches to behaviour change counselling may be required.

Kennedy et al. (2010) also found that the implementation of SMS following training to be problematic in some respects. In particular GPs found it difficult to utilise some of the SMS tools included in the training leading to the conclusion that opportunities were missed to address patient's self-management needs. The challenges of implementing SMS for clinicians are noted in the context of the environment they operate in. Principally working with sometimes complex cases in a busy setting which is target driven militates against the time needed to implement a self-management approach.

3.3 Countering barriers to integration

Having recognised and identified potential barriers to the implementation of SMS the next step is to put in place a strategy to eliminate or attempt to minimise the barriers. Lawn (2007) suggests that formalised frameworks are a good starting point in addressing barriers to SMS. For example the PRACTICE model devised by the Royal Australian College of General Practitioners (RACGP 2006). This model is evidenced based and presents a structured approach to understanding and addressing potential barriers to the implementation of preventative healthcare and SMS. The model is reflective and consists of a checklist of issues to be addressed.

Additionally a large UK initiative named The Year of Care (YOC) (Diabetes National Training and Support Programme, 2011) looked at care planning in Diabetes and established a model known as the YOC House. To date the initiative has delivered a national training and support programme to 1,000 healthcare practitioners across England. They strongly argue a case for attitudinal training, and crucially, the need for changes in attitude and changes in practice to occur simultaneously. This is based on the view that a change in structure without attitudes is ineffective and possibly unsustainable. They identified two strongly held attitudes among some staff, which made it difficult for them to take on the SMS role – "We do this already" and "Not suitable for 'our patients' who 'lack motivation'; not our role". They conclude that a major success of their training has been its effect on the attitudes of participants.

Question 4: What gaps in SMS training and education are identified in the literature?

Battersby et al. (2008) analysed the gaps identified from their comprehensive, mixed methods study and made a number of recommendations covering the i) content and ii) delivery of the training iii) governance surrounding the training and iv) information resources supporting SMS. The recommendations are generic and likely to be transferable to the UK health system. The rest of this section is based on Battersby et al's. (2008) analysis.

4.1 Training content

The training content should be based on the core skills identified (table 2) and cover the domains of person centred skills, behaviour change skills and organisational/system skills as well as taking into account the attitudes of staff in relation to SMS. The content will inevitably vary by profession, location and context.

A major emphasis within the core skills should be on teaching behaviour change and this should be done in an integrative way which reflects their application in clinical practice situations/scenarios. Similarly in terms of core skills it is important to focus on the interaction between psychological factors and chronic conditions.

In order to facilitate the translation of training into practice there are three key considerations: 1) workforce training should be matched to the undergraduate curriculum; 2) training must promote safety, competence and cultural awareness (including the use of culturally respectful language); 3) service users, including minority groups, should be involved and consulted in the development of training so that it more closely matches their experience and needs.

4.2 Training delivery

Recommendations are made which would lead to better delivery of training. Firstly in terms of personnel, there is a need to be inclusive in involving a range of health professionals, health profession organisations and multi-disciplinary trainers in the promotion and delivery of training. Also it would be beneficial to include managers so they understand the objectives and motivation behind the training. The training should be provided for both uni-disciplinary and multi-disciplinary groups and tailored to these groups and local contexts as appropriate. Training should be delivered with more flexibility to allow better access for a range of individuals and particularly to accommodate those working in remote and rural areas.

The involvement of multi-agencies in the support of those with chronic conditions should lead to training being incorporated in inter-agency activities if possible with the added aims of encouraging networking, shared learning and team working. The contribution of other parties to potential involvement in SMS training should also be explored, for example industry and higher education institutions providing post-graduate courses (which is already happening in Scotland).

The actual delivery should subscribe to adult learning principles and be interactive and experiential. In particular the training should include interactive skill development, modelling behaviour techniques and skill integration techniques.

Deficits have been identified in the way training is currently evaluated and there is the potential to improve this by more rigorous assessment of its value. This could be achieved by funders requiring that the SMS training provided on their behalf be delivered to agreed competency standards and that independent evaluation of this should be built into the funding agreement and planned at the outset. Further it would be important to ensure that the outcomes of the evaluations were widely available in the interests of transparency. Related to evaluation for quality assurance purposes, there may be a role for some kind of regulatory monitoring (e.g. government) to ensure that minimum competency standards are being met.

Following completion of the training, its value could be consolidated and enhanced by making sure that mentoring systems are in place to support and develop those who have participated in it.

4.3 Governance surrounding SMS training

There are a number of governance considerations which should be built into the development of SMS training to assure its quality and value. These include the setting of national core competencies and training delivery standards. Ideally these competencies and standards should be endorsed by the relevant health professional bodies. Training should be evidence-based, validated, evaluated and aligned to the Government policy agenda where possible.

4.4 Information resources

There is scope for improving the more effective utilisation and dissemination of information supporting SMS. In terms of utilisation there is the potential for promoting existing web resources to increase the uptake of information. There is a need to supplement existing resources by developing and adding new materials (e.g. guidelines, evidence based principles) that are user-friendly for both health professionals and service users. A number of suggestions are made for widening the dissemination of information. These suggestions include setting up on-line databases of training resources and materials for easier access by healthcare professionals. Similarly the creation of peer support networks on-line e.g. shared spaces, community networks. It would be important to support such on-line resources with relevant training in their use.

Summary

It is acknowledged that simply providing education alone for healthcare practitioners is not likely to bring about the transformational change required for self-management to become truly embedded across the health system. But it is a critical part of the jigsaw, therefore it is important to gain a more comprehensive understanding of what education is required and how it should be provided.

Evidence related to education and training of healthcare practitioners to enable them to support people to self-manage is a relatively new area of investigation. Knowledge and thinking continues to emerge associated with a wide range of interrelated themes or areas. As expected, and as with self-management itself, it seems that there is no one education solution to suit all groups of health practitioners or all clinical areas. Some of the literature focuses on specific skills or attitudes practitioners need to develop, strategies to adopt, organisational process or, to a much lesser degree, educational approaches. When considering this range of literature from a practitioner perspective they can be loosely grouped into the following areas:

- the way healthcare practitioners engage and interact with people with LTCs (and their family or carers)

- how they work with their colleagues (across all sectors)

- the specific knowledge, skills and attitudes they require to adopt and then integrate a self-management approach

- their capacity to influence and implement system and process change, including capacity to develop solutions to overcome barriers

The literature does highlight a number of common points related to education for health practitioners to support self-management. Some of these are noted below:

Person centred approach
- The literature describes self-management as a person centred approach, as evidenced by some of its key components such as exploration of experience, understanding the whole person, finding common ground, health promotion, and enhancing the relationship to encompass caring and power sharing (Little et al. 2001). By definition, communication skills are central to implementing this person centred approach.

This is further emphasised by the findings that people with LTCs want to involve themselves (or their representatives) in the development and evaluation of SMS training for healthcare professionals. As well as consumers it is also important to consider the input of practitioners themselves in the development of SMS training.

All of this is consistent with the view that self-management education can emerge from a co-creation paradigm rather than having an external expert or didactic frame.

Specific skills and knowledge
- The specific SMS skills required by healthcare practitioners to support people to self manage can be grouped into three main areas: person centred care (already noted above), behaviour change (with a focus on self-efficacy), systems/organisation skills (Battersby et al. 2008). Given the multiple theories associated with any one of these areas the literature suggests that practitioners would benefit from a comprehensive set of skills rather than focusing exclusively on one model.

Support for learning
- The literature indicates the need for continued support for practitioners to enable change in practice, and to maintain this change. Traditional ways of doing this might be to provide a mentor or support network in the workplace so people can continue to develop their thinking and practice. However, some of the literature highlighted a focus on integrated behaviour change rather than the simple acquisition of skills. This then becomes about stopping people from reverting to type once the support for new ways of working has been withdrawn.

Integrated behaviour change links directly to earlier discussion about the importance of practitioners being able to influence organisation processes and procedures, as these are some of the things that can act as either enablers or challenges. Learning therefore needs to be part of a wider process of change rather than stand alone.

There is some indication of variations in undergraduate curriculums being geared up for teaching SMS skills. The therapies professions (e.g. AHPs and psychology) were identified as being more ready to adopt self-management perspectives, although the literature did note that individual professions have strengths and weaknesses and particular learning needs.

Dominant ways of thinking and doing

- Linked to the need to support learning is the issue of the influence of current thinking, beliefs and attitudes related to self-management. These can have a significant impact on i) how the SMS provided is experienced by people, ii) practitioners engagement with education related to SMS and iii) practitioners capacity to change practice. It is therefore vital that education addresses this aspect.

One of the challenges noted in the literature is that self-management can be seen as being about instilling a new way of practising which may be at odds with practitioner's preferred approach and that which they feel comfortable with. Alongside this is the possibility that the wide definitions and beliefs about what constitutes self-management mean that it can be possible for a practitioner to believe that their practices are fully supporting and enabling self-management without this being fully reflected in their behaviours and actions. For example, some research suggest that some practitioners may take a compliance orientated approach to self-management, which may not be helpful and is not necessarily consistent with self-management theory.

One of the challenges surrounding the training for staff was uncertainty about the value of the time commitment required to undertake the education. Similarly skill acquisition was an issue with participants finding it testing to adapt their normal practice of informing and advising to eliciting thoughts and feelings and inputting into patient generated plans. The literature noted that the barriers to implementing behaviour change techniques were further reinforced by service challenges, predominately again time and the pressure to conform to traditional bio-medical aspects of the consultation.

This literature review does not offer a simple education solution but raises a number of issues or points intended to inform further discussion. One of the key findings is associated with having a range of options and flexible provision. The literature identifies a wide range of training providers and delivery formats and notes the benefits of this. Although it did not appear in the literature reviewed in this document, the voluntary sector is increasingly recognised as both a key provider of education to support self-management and an environment where practitioners can learn about self-management support e.g. through practice placements for pre-registration students. One of the challenges in identifying what works for the education of practitioners is the way in which training is currently evaluated and there is the potential to improve this by more rigorous assessment of its value.

Appraising the evidence has increased our intelligence and understanding of this area of practice and NES are keen to continue to work in partnership with partners in NHS boards, the third sector, education providers and other stakeholders to take forward this critical agenda.

Appendix 1 – The Literature Review

Conducting the Review

The literature was located by a variety of methods. In the first instance the NHSScotland Health Management Library was approached to carry out a literature search. This was supplemented by a supplementary search carried out in the NMAHP directorate to seek out additional references. These two principal searches were backed up by a cited reference search on key references, a search for grey literature on the Internet and contact with expert authors in this area.

The Health Management Library searched Medline, Embase, CINAHL and their own database. The NMAHP search also covered these databases and

ERIC (Education Resources Information Centre) and HMIC (Health Management Information Consortium).

A key consideration in the literature searches was the terminology to be used to describe both long term conditions and self-management. In the literature a number of synonyms are used for both these terms and it was important ensure that the broad range of these similar terms were represented in the searches. The table below summarises the range of terms used. These were initially based upon those used in the Health Foundation document and supplemented by a review of key words used to index a number of important papers in this area.

self-management	long term conditions	related terms
self-care	chronic conditions	coping skills
self-efficacy	chronic care	behaviour change
self help	chronic disease	care plans
self-management education		
long-term care		
disease management		

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Appendix 2 – Evidence Based Principles to Underpin SMS Training & Education

Principle	Rationale
1. Brief Targeted Assessments to Guide SMS	The assessment of clinical severity, functional status, patients' problems and goals, self-management behaviours and barriers to self-management is integral to SMS
2. Information Alone is Insufficient to Improve Patient Outcomes. Information should be used to guide shared decision making	Shared decision making should target evidence-based educational interventions that promote skill development. As an example a review of adult asthma self-management education showed that information-only interventions did not have a significant effect
3. Use of a Non-judgmental Approach	Clinicians more effectively support patient self-management when they provide evidence-based information with a non-judgmental approach
4. Collaborative Priority and Goal Setting	Collaborative identification of priorities, goals, and specific plans for goal achievement improves self-management and outcomes.
5. Collaborative Problem Solving	Collaborative problem solving improves self-management and outcomes.
6. SMS by Diverse Providers	Diverse professionals and laypersons can effectively deliver SMS interventions if they have clearly defined tasks and roles and are trained to use evidence-based interventions.
7. Self-Management Interventions Delivered by Diverse Formats	Self-management interventions can be effectively delivered via diverse modalities, including individual, group, telephone and self-instruction formats. Much of the evidence for the benefits of diverse modalities comes from the smoking-cessation literature.
8. Enhance Patient Self-Efficacy	Self-efficacy is defined by Bandura as "people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives." Enhancing patient self-efficacy regarding key chronic illness management tasks improves the process and outcomes of care
9. Ensure Active Follow-Up	Ongoing follow-up, supported by feedback and reminders to both clinicians and patients, helps sustain self-management behaviours and improves patient outcomes.
10. Employ Guideline-based Case Management for Selected Patients.	Case management can improve self-management and patient outcomes if (and only if) it is goal directed and guideline based.
11. Linkages to Evidence-Based Community Programmes	SMS should include community-based self-management programs that are evidence-based
12. Multi-faceted interventions are more effective than single-component interventions.	Effective SMS is typically provided by multi-faceted rather than single-component interventions. Multi-faceted interventions include patient registries that identify patients with specific chronic conditions and linkage to appointment recall systems, evidence-based guidelines and outcome measures.

Source: Battersby M, Von Korff M, Schaefer J, Davis C, Ludman E, Greene SM, Parkerton M, Wagner EH (2010) Twelve evidence-based principles for implementing self-manage support in primary care. The Joint Commission Journal on Quality and Patient Safety. 36(12), 561-570.

Appendix 3 – Areas for Upskilling the Primary Care Workforce

Lawn (2007) identifies a number of specific areas where upskilling is required. These cover both the prevention and self-management roles in relation to chronic conditions and appear transferable across both these dimensions:

- Shared /consistent definitions of prevention and self-management and the acknowledgement of the need for a conceptual framework to provide an overall vision for implementation.

- Understanding the inherent relationship between prevention and self-management as part of a population health/public health approach that recognises and incorporates the social determinants of health and micro (individual level), meso (healthcare organization and community level), macro (health service, government level) relationships.

- Patient education and communication techniques and tools that more collaboratively involved the person in planning, decision-making and activities to promote better self-management. The important first step is engaging patients in the first place, which is a skill in itself that is often overlooked. Coulter (2007) argues that health literacy is fundamental to patient engagement and to addressing health inequities. "If people cannot obtain, process and understand basic health information, they will not be able to look after themselves well or make good decisions".

- Training that supports cultural, philosophical and organisational shift towards placing the person at the centre of the collaborative care process with an emphasis on inclusion, participation, quality of life and wellbeing for the person

- Effective techniques to support behaviour change by the person that incorporate an understanding of self-efficacy, motivation, stages of change, the role of peers, reasons for noncompliance/adherence, and goal setting. Most current self-management models are based on psychological behaviour change principles but do not provide practitioners with these and other micro skills necessary to assist patients' behaviour change, especially where barriers exist that need to be understood,

acknowledged and overcome. Primary healthcare workers need training in these approaches that also fosters skills acquisition through practice rather than predominantly didactic approaches to training delivery (Gale, personal correspondence, 2007). A further problem is that health professionals are often trained in limited models of behaviour change, with the transtheoretical model being dominant. However, there are multiple theories of behaviour change which together have the potential to provide health professionals with more comprehensive skill sets. These include the health belief model, theory of reasoned action, social cognitive theory, transtheoretical model, interaction model of client health behaviour, relapse prevention model and health promotion model. In addition to this, there are a number of models to promote health which could be useful for primary healthcare professionals to understand (Pender, Murdaugh & Parsons, 2006).

- Organisational change and improvements and how to achieve them through tools such as Assessment of Chronic Illness Care (ACIC) evaluation and Plan Do Study Act (PDSA) cycles

- Multi-disciplinary teamwork and greater collaboration and communication between primary healthcare providers

- Maximising the supportive organisational infrastructure through improving the capacity of information technology to underpin chronic disease prevention and self-management

- Effective use of evidence-based guidelines to support clinical decision-making and planning of service delivery

- Effective use of existing resources such as Lifescripts, SNAP, the RACGP Red and Green Book

- Specific skills required when supporting people with specific needs, for example, people with mental illness, young people, people with drug addictions

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