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Implementing, embedding and integrating self-management support tools for people with long-term conditions in primary care nursing: A qualitative study☆

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ABSTRACT

Background: An implementation gap exists between policy aspirations for provision and the delivery of self-management support in primary care. An evidence based training and support package using a whole systems approach implemented as part of a randomised controlled trial was delivered to general practice staff. The trial found no effect of the intervention on patient outcomes. This paper explores why self-management support failed to become part of normal practice. We focussed on implementation of tools which capture two key aspects of self-management support – education (guidebooks for patients) and forming collaborative partnerships (a shared decision-making tool).
Objectives: To evaluate the implementation and embedding of self-management support in a United Kingdom primary care setting.
Design: Qualitative semi-structured interviews with primary care professionals.
Settings: 12 General Practices in the Northwest of England located within a deprived inner city area.
Participants: Practices were approached 3–6 months after undergoing training in a self-management support approach. A pragmatic sample of 37 members of staff – General Practitioners, nurses, and practice support staff from 12 practices agreed to take part. The analysis is based on interviews with 11 practice nurses and one assistant practitioner; all were female with between 2 and 21 years' experience of working in general practice.
Methods: A qualitative design involving face-to-face, semi-structured interviews audio-recorded and transcribed. Normalisation Process Theory framework allowed a systematic evaluation of the factors influencing the work required to implement the tools.
Findings: The guidebooks were embedded in daily practice but the shared decision-making tools were not. Guidebooks were considered to enhance patient-centredness and were minimally disruptive. Practice nurses were reluctant to engage with behaviour change discussions. Self-management support was not formulated as a practice priority and there was minimal support for this activity within the practice: it was not auditable;

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was insufficiently differentiated from existing content and processes of work to value in its own right, and considered too disruptive and time-consuming.
Conclusion: Supporting self-management through the encouragement of lifestyle change was problematic to realise with limited evidence of the development of the needed collaborative partnerships between patients and practitioners required by the ethos of self-management support.
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What is already known about this topic?

- Practice nurses are increasingly responsible for most long-term condition management in primary care.
- The development of more collaborative patient–practitioner relationships is key to the ethos of supporting patient self-management of long-term conditions.
- Whilst ostensibly widely and rhetorically valued, the necessary increased patient involvement in self-management support via the consultation process is challenging for practitioners to implement in practice.

What this paper adds

- The current organisational priorities of General Practice means that the work needed to implement self-management support remains under-initiated and valued by the current system so is not given the priority required for it to be embedded in the day-to-day work of primary care.
- Displacing existing practices in order to incorporate new ones is discouraged by the task-driven nature of nurses' routines that hinder incorporating alternative ways of working.
- Underlying scepticism of the will of many patients to take adequate responsibility for their health undermines the motivation of some nurses to engage with self-management support activities.

1. Introduction

A randomised controlled trial of an approach to improve the health outcomes of patients with long-term conditions through improving the self-management support they received from primary care showed no effect (Kennedy et al., 2013). The trial was one of the largest ever to be conducted of self-management support, recruiting 5599 patients. This paper uses qualitative methods to explore the work of self-management support and explain why the implementation of a systemised evidence-based approach failed to engage the nurses tasked with supporting patients to self-manage.

The organisation of care for people with long-term conditions is in transition and self-management support policies have been designed to enhance peoples' self-management capabilities aiming to improve health outcomes and reduce the fiscal burden on health care systems (Department of Health, 2005). Self-management has been defined as: 'the care taken by individuals towards their own health and well-being: it comprises the actions they take to lead a healthy lifestyle; to meet their social, emotional and psychological needs; to care for their long-term condition; and to prevent further illness or accidents' (Department of Health, 2005). In relation to long-term condition management and based on a systematic review, the interventions most likely to be effective in the context of primary care were engagement for self-management support through education and training for general practitioners and practice nurses (Dennis et al., 2008). Primary care potentially provides ready access and continuity of care for patients and therefore an appropriate location for guideline-based *disease management* programmes for patients, and more recently as a key provider of self-management support (Truglio et al., 2012). In United Kingdom primary care, long-term condition management operates through an increasingly biomedical, specialised and reductionist framework, partly as a result of the Quality and Outcomes Framework (DoH, 2004), a system of payment to practices for activities done and outcomes achieved. To gain through the pay for performance system, practices have to demonstrate through clinical information systems using computer templates, the undertaking of specific processes and tasks (such as setting up a register of patients with hypertension and regular recording of blood pressure with an aim of ensuring blood pressure is controlled according to a target). These financially incentivised tasks have been shown to have both intended and unintended consequences and are, in the case of long-term condition management, usually delegated to practice nurses (McDonald and Roland, 2009).

Self-management support holds out the offer of a more patient-centred, social and psychological approach. There have been numerous studies of the effectiveness of self-skills training delivered to patients and the factors relating to acceptability and uptake by patients of one-off training courses. We know much less about the implementation of a whole systems approach to self-management support and an implementation gap has been identified between the national aspirations for self-management policy and local means of delivery (Lee et al., 2006; Rogers, 2009). Thus, there is a need to understand how a systemic approach to self-management support reconfigures existing relationships, communication and practices and how the principles of a whole systems patient-centred approach to self-management can translate and become embedded and integrated into routine practice (Gray et al., 2011; Macdonald et al., 2008). The latter is particularly salient in a context where the labour of primary care professionals has ostensibly become biomedical and bureaucratic due to the pressures and demands of governance arrangements linked to pay-for-performance (Doran et al., 2011) and in the diverse and widely spread context of primary care (Greenhalgh et al., 2004).

We have based our theoretical understanding of the implementation of self-management support in primary

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