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GP with special
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Oldham

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Welcome to the second edition of Joint Matters, the clinical update from Arthritis Research UK. Joint Matters provides short, topical features from the world of musculoskeletal health, keeping you up to date with the latest clinical information, developments and conversations.

In this edition we focus on supporting selfmanagement. People with musculoskeletal conditions tell us that self-management support is really important in helping them to feel in control of their condition and improve their quality of life. However, for many healthcare professionals it can be difficult to identify the most effective way to provide this support and empower patients to self-manage. This edition throws a spotlight on approaches to supporting self-management, providing you with possible solutions and ideas to help improve the quality of life for people with arthritis.

As you might be aware, Arthritis Research UK and Arthritis Care have joined together to do more for people with arthritis. We are currently working on creating the new charity – building on the best of

both organisations to create an organisation that will do more for, and with, people with arthritis. We are no longer just a medical research charity or just a care charity – so we need a new brand and a name that encapsulates all that we do for people with arthritis. This will take place over the next few months and we'll be announcing the new name and relaunching the charity in the summer so watch this space!

We hope that you enjoy this edition of Joint Matters, and we welcome any feedback or comments. If you are interested in contributing to the next edition of Joint Matters, we would love to hear from you. Please get in touch with the us at professionalengagement@arthritisresearchuk.org



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1 IMPLEMENTING SHARED DECISION MAKING IN MUSCULOSKELETAL CARE

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Shared Decision Making

Working with the Right Care Shared Decision Making programme to promote Shared Decision Making between patients and professionals.

Other questions I would like to ask during my consultation:

1.
2.
3.
4.
5.

Remember, you can bring someone else with you to your appointment, such as a relative, carer or friend.

Your health, Your decision

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

Ask 3 Questions

NHS

What are my **options**?

What are the **pros** and **cons** of each option for me?

How do I get **support** to help me make a decision that is **right for me**?



AQuA
Advancing Quality Alliance

Right Care
Shared Decision Making
Programme

<http://www.advancingqualityalliance.nhs.uk/SDM/>

This short article discusses the implementation of shared decision making (SDM) in the community musculoskeletal service in which I work. It also explains some of the lessons we learnt from delivering three large Advancing Quality Alliance (AQuA) collaborative programmes aimed to implement SDM in clinical practice.

SDM between patients and clinicians has been described as a 'meeting of experts'. As clinicians we are experts in the diagnosis, prognosis, treatment options and potential outcomes, while our patients are experts in

their own personal circumstances, attitude to risk and personal preferences between possible treatment options.

Implementing SDM should, on the face of it, be relatively straightforward. Clinicians, by virtue of their training, are armed with the knowledge and patients, with their lived experience, have the skills to make decisions.

So where are the problems? Evidence from the National Patient Survey¹ shows that over the past 15 years about 50% of patients want more involvement in managing their care, while looking at unwarranted variation

in Rightcare² data packs show there is still much to do.

What lies at the heart of SDM is quality, ensuring patients are empowered to make the right decision for themselves. The clinician's role is the communication of unbiased information in a format patients can understand and act upon. Unfortunately, when the drive to implement SDM comes from commissioners, the prime motivation is often perceived as financial and SDM as a tool to lower rates of intervention and ration healthcare.

The lessons from the AQuA collaboratives revealed three challenges that need to be overcome to achieve successful implementation:

1. Organisational support at a senior level
2. Using tools to empower patients such as decision aids and “ask three questions” leaflets³
3. Changing clinician's attitude

While all these are significant, the most important is the clinician's attitude. What needs to change is the ‘natural paternalism’ of many clinicians. This is not a criticism of their ability to consult but a realisation that doctors, with the exception of General Practice and Mental Health, are not trained in consultation skills.

We have found that Motivational Interviewing training is often the “eureka” moment, when there is a realisation that the language we use and how it is said can influence patient choices. Additionally, we have found that short decision aids used within the consultation help to standardise the way options and risks are explained to patients. They also act as a catalyst to achieving an inclusive conversation with patients. Most NHS decision aids are too long and not designed for use with the patient and we have opted to use Option Grids developed by Prof Glyn Elwyn⁴.

This multimodal approach to implementation can be successful. Over the past 12 months we have been concentrating on SDM in our



knee arthritis pathway. During this we have seen a 29% reduction in arthroscopy and 18% reduction in knee arthroplasty rates, without the use of any thresholds. This was supported by a Commissioning for Quality and Innovation (CQUIN) agreed with our CCG, which has covered the costs associated with implementation.

References

- 1 england.nhs.uk/statistics/statistical-work-areas/patient-surveys/
- 2 england.nhs.uk/rightcare/products/ccg-data-packs/
- 3 <http://www.pat.nhs.uk/downloads/patient-information-leaflets/other/Ask%203%20Questions%20Leaflet.pdf>
- 4 health.ebsco.com/products/option-grid

2 FIBROMYALGIA- MANAGEMENT IS MORE THAN JUST DRUGS

Anish Kotecha, GP Partner with a special interest in education, South Wales

Fibromyalgia is a chronic condition which causes widespread pain. There is currently no cure. There are drug treatments that some patients find helpful, though it's common to experience side effects with these medications. However, non-drug treatments or self-management techniques, such as exercise, psychological therapies, or learning to understand the condition through education, are just as important. The clinical approach should be tailored to each individual to meet their treatment goals.

Patient education allows patients to understand their condition and also what can be achieved in terms of treatment. Teaching patients simple breathing exercises and showing them how to adjust their lifestyle can help reduce their stress and frustration. If these simple measures prove ineffective, cognitive behavioural therapy can help.

To help increase their confidence and give them focus, people with fibromyalgia should be encouraged to continue going to work, if possible.

Exercises such as swimming, walking and pilates can also help increase their sense of wellbeing. It is important to start at a level easily tolerated and gradually build up muscle strength, flexibility and stamina. It is easy for people with fibromyalgia to overexert themselves when symptoms are minimal, so they should be reminded to pace themselves by balancing periods of activity with rest to avoid exhaustion.

A fundamental part of improving the person's symptoms of fibromyalgia is ensuring they get enough good-quality sleep. Patients can improve the quality of their sleep by following some simple recommendations. They could try having a warm bath before bedtime or listening to music. It's important to develop a new sleep routine and to avoid late-night caffeine, daytime sleeps and watching TV in the bedroom.

Joining local support groups and online forums can allow patients to discuss experiences and share their stories. They should be encouraged to try all of the recommendations above and update their doctor on the benefits to decide whether further medical assistance is required.

Further information can be found at the following:

nhs.uk/conditions/fibromyalgia/

gpcpd.walesdeanery.org/index.php/understanding-fibromyalgia





**EXERCISES SUCH AS
SWIMMING, WALKING AND
PILATES CAN ALSO HELP
INCREASE WELLBEING.**

3 EMPOWERING PATIENTS: USING TECHNOLOGY TO SUPPORT SELF-MANAGEMENT

Charlotte A Sharp, Clinical Academic Fellow & Rheumatology ST5, Manchester

Self-management enables patients to manage the ‘physical, emotional and social impact’ of ill-health¹. As a key facet of patient-centred care, it may improve patient outcomes and experience², and is particularly important for those with long term conditions³.

NHS policy prioritises the exploitation of technology to advance patient care⁴. Empowering patients to use technological resources provides an obvious opportunity to fulfil this aspiration. But what are these resources, and what should healthcare professionals consider when actively supporting self-management using technology?

At the simplest level, any website containing information pertinent to a patient’s health may aid self-management as education lies at the heart of this endeavour. Interactivity varies, and websites may be dedicated specifically to self-management, symptoms or conditions. Peer support, through online fora and social media, enables individuals to share experiences using accessible formats like videos and chat functions.

The boom in smartphones and wearable devices has generated apps with a range of features; monitoring exercise, recording disease activity⁵, logging medication, motivating behaviour change and booking appointments, amongst others. Integration of data from these apps into routine clinical care, combining self-management with the use of patient-generated data during clinical consultations, is on the horizon⁶.

Signposting websites displaying the Information Standard and apps listed in the (albeit currently limited) NHS apps library may allay concerns about advocating ‘unreliable’ resources. Having an encyclopaedic knowledge of these resources is impractical but becoming familiar with a selection takes little time (Table 1). The common misconception that advocating technology may exclude large numbers of patients is not borne out by the facts: in 2017, 88% of households had internet access and 76% of adults owned a smartphone⁷. Whilst using technology for self-management may not appeal to everyone, healthcare professionals have a responsibility to be aware of the options and signpost appropriately, as a key facet of patient-centred care.

References

1. de Longh A, Fagan P, Fenner J, et al. A practical guide for self-management support: Key components for successful implementation: Health Foundation 2015.
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4. NHS England. NHS Five Year Forward View. *Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority* 2014
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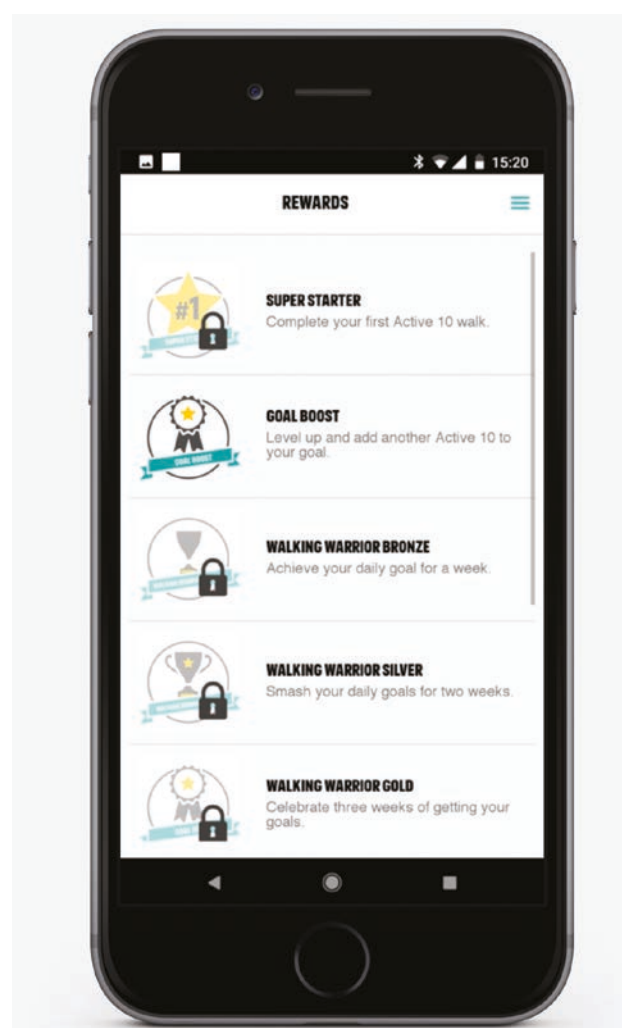
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Table 1 Examples of self-management resources

Resource	Example	URL
General health information	NHS choices	nhs.uk
Self-management resources	Self-management course information Self-care toolkit	selfmanagementuk.org/ nhs.uk/Planners/Yourhealth/Documents/Self%20Care%20Toolkit%20Booklet%20-%20Oct%2010%20-%20READ.pdf
Symptom management	The pain toolkit	paintoolkit.org/tools
Peer support	Health Unlocked	healthunlocked.com/
Patient experience videos	Health Talk	healthtalk.org/
Motivating apps	Active 10 Walking Tracker	apps.beta.nhs.uk/active-10/

- i The Information Standard is a certification scheme for health and social care information, providing a quality mark which indicates that an organisation is a reliable source of health and social care information [england.nhs.uk/tis/ Accessed 14/03/2018]
- ii The NHS apps library reviews apps for safety and relevance [apps.beta.nhs.uk/ Accessed 14/03/2018]
- iii Inclusion of these resources does not indicate endorsement of that resource, its content, or any product or service it may provide. All links were active at the time of going to press.

Screen shot from the Active 10 Walking Tracker



4 HEALTH COACHING TOWARDS SELF-MANAGEMENT IN FIBROMYALGIA

Tim Williams, GP and Community Pain Specialist, Sheffield

The assumption that the successful management of long-term conditions depends more on the health care professional than the patient is not only incorrect, but as it turns out, also unsustainable.

If instead, we assumed our patients had the most vital role to play, then we would start with them, refer to them and their ideas and encourage them to continue to think for themselves. We would no longer assume to be the experts – knowledgeable and sage-like in our advice. Rather, we would share relevant information and experience and ask insightful questions to encourage patients to come up with their own ingenious and sustainable solutions.

Coaching pointers

1. **Establish what's important for your patient.**
2. **Focus on achievable outcomes.**
3. **Allow time to consider what stops them achieving the outcomes they want.**
4. **Encourage patients to come up with their own ideas before offering yours.**

This is the art of health-coaching. Not telling or advising but listening and encouraging. This is so far away from our traditional training, that we must take time to reset our way of being with patients for them to succeed. It is not about me anymore but about them.

This is quite liberating for practitioners who have spent years trying to 'fix' people – and don't worry I recognise that there are times we need to take the lead, particularly in emergencies and just sometimes because that is what some patients want. The problem is that whilst we remain utterly responsible for it all of it, patients will find it impossible to be responsible for any of it.

Many of our patients have been well trained, to be passive recipients of healthcare. We now need to gently wean them – and ourselves – off this habit and allow them to contribute something more themselves.

We can't force people to self-manage and of course, some patients will be more resourceful than others. However, we can coach them and set up our conversations and our systems to at least facilitate and not obstruct the process.

Despite the current financial imperative that patients engage in more self-management, it's always been the right thing to do.

Fibromyalgia (FMS) affects between 3 and 6% of the population – a similar prevalence to type 2 diabetes. It is a long-term condition and the key to successful treatment is self-management.

On my journey to supporting pain self-management, I had the following 3 penny-drop moments which may be helpful to others.

1. Acceptance that persistent pain is a long-term condition

Agreeing on this moves the conversation away from **cure**, or being pain-free, which is unrealistic – towards **control**, which is the goal of managing any long-term condition.

In cases where a patient has persistent pain, of which FMS is a good example, it is the nervous system which is faulty and though their situation can be improved, it is unlikely to return to normal.

Knowing that FMS is a long-term condition also means that we can take our time in assessment and consider self-management options, rather than simply giving the next strongest analgesic we can think of.

2. It's not all about you.

As clinicians, our years of training have set us up as the experts who are consulted for our highly tuned diagnostic skills and advice on appropriate, evidence-based treatment. Patients with long-term conditions use about 4 hours of clinician time per year, which leaves around 8,756 hours where they are self-managing – without us!

If we want patients to take **responsibility** for their health, then we need to step back where appropriate (which is more often than we might think) and coach them to find their own **ability-to-respond** to their condition.

3. It's not all about the pain.

The effects of pain are far reaching in the life of someone living with it. For many it is all consuming and dominates all aspects of life including sleep, mood, weight, exercise, relationships, work etc. Yet, our focus and that of the patient is set narrowly on reducing the severity of the pain.

Successful pain-management can more often be achieved by shifting the focus from pain towards these other aspects of life where progress can be made.

Pain, although persistent, then becomes a smaller part of the overall picture as people get their lives back.

Resources for clinicians

paintoolkit.org

paincommunitycentre.org



5 PHYSICAL ACTIVITY, THE 'SUPER PILL'...?

Onebieni Ana, GP with special interest in musculoskeletal medicine, Bedfordshire

Imagine a drug so powerful it could manage diabetes, cardiovascular disease, depression, osteoarthritis and even certain cancers. Imagine a drug with minimal side effects, available to all age groups and fully approved. If prescribed correctly it could potentially reduce the financial burden on the NHS. If this drug existed would you prescribe it?

This 'drug' does exist. It is called 'physical activity'. The notion that moving about can count as a 'super pill' may seem far-fetched, but the evidence is overwhelming. Why? It works at even the most basic level of our bodies' functionality: the cell. At the cellular level physical activity works away to inhibit low-grade chronic systemic inflammation, the root cause for many pathologies.

Activity is not just a viable prevention option for a myriad of conditions. It can even be used to treat certain conditions, particularly when it comes to musculoskeletal conditions. Physical activity can improve posture and gait imbalances, for instance. Regular physical activity has been proven to reduce osteoarthritis by between 22 and 80% ^(1,2).

So how do you prescribe this 'super-pill?' Your role is not just to prescribe, but to encourage and reinforce good behaviours, and challenge unhelpful beliefs. It can be a tall order. So Public Health England has launched a training initiative, the 'Clinical Champions' programme, to help clinicians across the country to highlight the importance of physical activity – and its harmful antithesis, inactivity.

The programme is designed especially for those in primary and secondary care, and can be tailored to the needs of each clinical interest.

So: what's the 'prescription'? Well, individuals should follow the guidelines as a minimum. If 65 years or older, strength training is needed at least twice a week, and balance and co-ordination exercises should also be done twice each week. Being less sedentary is very important: move your body regularly, whether it's to dance, to walk or simply to do the gardening. It even helps improve mental health.

If this was a pill, it's one we believe most clinicians would want to prescribe.

References

1. Stay Active Start Active 2011, based on U.S Department of Health and Human Services Physical Activity Guidelines Advisory Committee Report (2008), Washington DC.
2. Bird (2014) Physical activity in the treatment of long-term conditions. BMJ Learning.



THIS 'DRUG' DOES EXIST. IT IS CALLED 'PHYSICAL ACTIVITY'.



**REGULAR ACTIVITY HAS
BEEN PROVEN TO REDUCE
OSTEOARTHRITIS BY
BETWEEN 22 AND 80%^(1,2)**



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