'It's coming at things from a very different standpoint': evaluating the 'Supporting Self-Care in General Practice Programme' in NHS East of England

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Aim: To undertake a service evaluation of the NHS East of England Supporting Self-Care in General Practice programme. **Background:** The number of people purported to live with long-term conditions continues to rise generating increasing policy emphasis on the importance of self-care. Previous work has highlighted barriers to implementing self-care interventions in general practice, including a lack of organisational approaches to providing self-care and limited engagement and training of healthcare professionals. In response to these barriers and policy drivers, NHS East of England Strategic Health Authority developed and commenced the Supporting Self-care in General Practice (SSCiGP) programme, which seeks to transform the relationships between people with long-term conditions and primary care practitioners. **Methods:** This was a mixed methods study, carried out over two phases, which included interviews, survey work and practice-based case studies. **Results:** This paper focuses on findings related to clinician and practice level change. Clinicians reported changes in their perceptions and in consultation practices following attendance on the SSCiGP programme. These changes were linked to empathy and patient-centredness that mirrored what patients valued in interactions with clinicians. There were qualitative and descriptive differences, but no statistically significant differences between clinicians who had and had not attended the SSCiGP programme. Time was recognised as a significant barrier to implementing, and sustaining skills learnt from the SSCiGP programme.

Greater impact at practice level could be achieved when there was whole practice commitment to values that underpinned the SSCiGP programme. There was evidence that such approaches are being incorporated to change practice systems and structures to better facilitate self-care, particularly in practices who were early programme adopters. **Conclusion:** This evaluation demonstrates that training around clinician change can be effective in shifting service delivery when sat within a cultural framework that genuinely situates patients at the centre of consultations and practice activity.

Key words: evaluation; self-care; training

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Introduction

Within England, ~15 million people are purported to live with long-term conditions, and the

number of those with two or more long-term conditions is expected to rise in the coming years (Department of Health (DH), 2008). While only accounting for 29% of the population, these patients account for ∼ 50% of GP appointments and 70% of inpatient bed days. Nevertheless, due to improvements in various support mechanisms, individuals are becoming better enabled to manage their long-term conditions through self-care (Kennedy *et al.* 2005, 2007; DH, 2011).

Supporting self-care has been central to health care in the United Kingdom for a number of years. In 2000, the NHS Plan made clear commitment to configuring services directly around patients, promising to become a resource which people routinely use every day to help them look after themselves (DH, 2000). The Wanless report (DH, 2002) reiterated the need to enable members of the public to self-manage their health if the NHS is to most successfully meet the challenges of the next 20 years. In 2004, self-care was included as one of the three developmental standards for patient focus in the national Standards for Better Health (DH, 2004). In the same year, the national Working in Partnership Programme (WiPP) was established to help general practice meet a commitment to encourage patients to take a more proactive role in managing their health and in using services most effectively, as part of the General Medical Services contract for General Practitioners. Within this initiative, WiPP actively promoted self-care to both ordinary people and to primary care healthcare professionals through the development of a number of training courses, practical tools and resources. In 2005, the Department of Health explained further their plans to develop support of self-care (DH, 2005). The importance of increasing self-care, patient-led approaches to care and shared decision making, continue to be emphasised under the new government arrangements outlined in the white papers *Equity and Excellence* (DH, 2010a) and *Healthy Lives, Healthy People* (DH, 2010b).

Previous evaluative work on implementing self-care interventions in general practice (DH, 2006; Greaves and Campbell, 2007; White *et al.*, 2008, 2009; Blenkinsopp *et al.*, 2009) has highlighted some major barriers to advancing self-care in primary care. Among these are a lack of organisational approaches to providing self-care, limited engagement from healthcare professionals, lack

of time to implement self-care and a paucity of training for staff on self-care skills.

In response to the above, and other related policy drivers, NHS East of England Strategic Health Authority (SHA) (a regional level government health body) noted the importance of promoting self-care as part of its strategy for managing long-term conditions (NHS, 2009). This strategy recognised the requirements of staff training in maximising the delivery of a self-care approach resulting in East of England SHA commencing the Supporting Self-care in General Practice (SSCiGP) programme, which seeks to transform the relationships between people with long-term conditions and health professionals. The three central objectives for the programme are: (1) to enable more supportive relationships between professional staff and people with long-term conditions; (2) to improve patient satisfaction ratings; and (3) to develop more effective partnerships and team working for the enhancement of services. The programme is delivered by a team of specially trained tutors, actors and patient co-facilitators who lead three, 2-h workshops that are practical, skills-based and use a significant amount of action learning (role play) to focus on building effective clinical/patient partnerships that make the best use of limited consultation times. Participants developed the skills for supporting patient self-care, based on the seven Common Core Principles of Self-care (Skills for Care: Skills for Health, 2008), in these three sessions and between through:

- Goal setting: setting personally relevant goals based on feedback from patients.
- Behaviour change in small steps: experimenting with skills in small, achievable steps in a safe environment that lead to successes.
- Skill rehearsal with feedback: receiving feedback and integrating that feedback into skill rehearsals with actors.
- Observational learning: seeing other clinicians successfully using the skills.
- Applying the skills in practice: trying out skills in the workplace and reflecting on those experiences.

The programme is aimed (where possible) at whole practices and seeks to be inspirational and culture changing as well as supportive of complementary regional and national initiatives,

such as personal health planning, expert patient programmes and the techniques of informed decision making. By May 2011, 232 individuals from 19 practices had completed the programme.

This paper reports the findings of an independent evaluation, commissioned by NHS East of England following the pilot phase of the SSCiGP programme, and completed by Leeds Metropolitan University. The paper focuses specifically on findings related to changes in clinician practice and wider impact on GP practice level systems and structures: that is, it focuses on clinician and practice level change.

Method

The overall evaluation design was one of mixed quantitative and qualitative approaches across two phases. Phase 1 had three purposes: (a) to collect general feedback on the experience of the programme,[1] (b) to begin to consider programme impact and (c) to further guide collection of realistic, meaningful and feasibly collectable indicators of impact to inform phase 2.

Phase 1

Phase 1 was wholly qualitative consisting of individual, in-depth, semi-structured interviews with:

- Nine patients.
- Thirteen clinicians (GPs, Practice Nurses, Nurse Practitioners, Nurse Consultants and Healthcare Assistants).
- Ten key stakeholders (involved in the development, implementation or delivery of the programme).

The patients and clinicians were accessed from four practices across the East of England. These four practices were purposefully chosen (from the nineteen practices that had completed the SSCiGP programme) for their diversity in terms of: practice size, practice demographics and being early, mid or late adopters of the SSCiGP programme. The key stakeholders represented people involved in the development and/or implementation of the programme, people involved in its delivery, and practice leads or managers who may not have participated in

programme training but who were involved in implementing programme learning at practice level. All interviews lasted between 15 and 55 min and were digitally recorded with participants' consent.

Phase 2

It became clear following analysis of phase 1 data that phase 2 data collection would be best served by a mixed methods approach that comprised the following elements:

- Practice-based case studies in a number of practices that had completed the SSCiGP programme.
- Interviews with clinicians who had not completed the SSCiGP programme (to provide a qualitative comparison to the interviews with clinicians who had completed the programme).
- A survey of clinicians who had, and who had not, completed the SSCiGP programme.

Case studies

Case study data were collected from three practices again purposefully chosen for diversity in terms of practice size, practice demographics, and being early, mid or late adopters of the SSCiGP programme. Using an illustrative (rather than theoretical) case study design (Yin, 1994: Thomas, 2011), a range of data were collected within each practice to provide information about what impact the SSCiGP programme had made. Each practice was visited for a one-day or two-day period to facilitate data collection. This period of time was a pragmatic decision based on minimising disruption within the practice while ensuring adequate data collection. To facilitate, guide and maximise the process of data collection during these visits, five domains of relevance, their areas for consideration, and related possible data sources had been identified following phase 1 (Table 1).[2]

Interviews with clinicians who had not completed SSCiGP

It was apparent following phase 1 that interview data needed to be collected from clinicians that

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[1] This process aspect is not reported here, rather we focus on outcome findings related to impact at clinician and practice level.

[2] Not all data were collected from all three practices. What was collected was dependent on whether data were relevant, available and if resources within the practice allowed time to provide it. The table indicates which data were gathered from which practice.

Table 1 Case study data collection design

Domain	Areas for consideration	Data Sources
Consultation	Patient centeredness (being empathic) – key values/skills, listening, patient expectations/beliefs; agenda setting, goal setting and action planning – done with, for or by patients?; responsibility for self-care	• Interviews with clinicians (all practices) • Interviews with key staff (those involved in bringing SSCiGP to the practice) (all practices) • Interviews with patients (all practices) • Data on consultation rates for LTC patients pre/post SSCiGP (where practices can provide this and are willing to share) (practice 1) • Survey (Cross region)
Systems and structures	Any changes in: structure of clinic sessions; Appointments (length, structure, nature of); follow-up appointments (mode of, frequency); care pathways (same, different, amended); data collected (new data, same but used differently, how does this feed back to improved care)	• Interviews with clinicians (all practices) • Interviews with key staff (those involved in bringing SSCiGP to the practice) (all practices) • Interviews with patients (all practices) • Documentary evidence from appointment schedules, review/recall systems for LTC patients (practice 1 and 4) • Observation and informal discussion about available information resources (e.g. photo's of information boards in reception areas) (practice 1 and 3) • Survey (Cross region)
Capacity building	Values, awareness and skills in communication being sustained/developed beyond programme; are self-care skills built into systems/structures (eg, in induction, in CPD, through appraisal), if so is this formal/informal	• Interviews with clinicians (all practices) • Interviews with key staff (those involved in bringing SSCiGP to the practice; all practices) • Documentary evidence (if/where available) from things like induction programme content, appraisal documents (asked in interviews but none available in any practice) • Observation and informal discussion about links between induction/appraisal and SSCiGP (all practices)
Strategy and leadership	Practice culture/ethos; are there formal self-care strategy (or other) documents at practice level; is self-care (and/or discussions of self-care 'cases') a standing item on practice meeting agenda; Does the drive to promote self-care at practice level rely on particular champions (if so how does this filter to others?)	• Interviews with clinicians (all practices) • Interviews with key staff (those involved in bringing SSCiGP to the practice) (all practices) • Interviews with PHP and LTC Leads within the case study PCT areas (Cross region) • Documentary evidence (if/where) available from practice meeting agendas (around self-care and LTC) (asked in interviews but none available in any practice) • Observation and informal discussion about self-care and LTC within the practice
Partnerships	What links (formally and/or informally) are made with the programme to: expert patient programme; personal health planning; patient involvement groups; voluntary sector or community activities; other practices	• Interviews with key staff (those involved in bringing SSCiGP to the practice; all practices) • Interviews with PHP and LTC Leads within the case study PCT areas (Cross region) • Interviews with patients (all practices)

CPD = continuing professional development; SSCiGP = Supporting Self-Care in General Practice; LTC = long-term condition; PHP = personal health planning; PCT = Primary Care Trust.

had not been through the SSCiGP programme to consider if their views on a range of emerging issues (empathy, responsibility, patient-centredness, practice ethos and practice commitment to self-care) differed from those who had completed the programme. In-depth interviews with six clinicians (GPs and Practice Nurses) from three practices that were signed up to commence the programme but had not yet done so were also therefore completed in phase 2.

Survey

A review of literature and information from phase 1's emerging findings were used to inform the design of items and scales in a cross-sectional survey. The Theory of Planned Behaviour was used as a framework to develop a new tool to measure the antecedents of clinician behaviour associated with facilitating self-care with patients who have long-term conditions using principles outlined by Ajzen (2002). Other constructs were developed for this study or adapted from existing previously validated instruments including a Guttman scale to measure perceptions about patients' roles in self-care, adapted from Clinician Support for Patient Activation Measure (Hibbard *et al.*, 2010); patient-centredness adapted from Kjeldmand *et al.* (2006); and clinical readiness for change items developed for this study.

The survey questionnaire was administered by post to all practitioners who had a role in facilitating patient self-care in practices that had joined the SSCiGP programme. Specifically, this included those who had already completed the SSCiGP programme and those who were signed up for the programme but had not yet undertaken the training. This therefore allowed for comparisons to be made on the constructs between those who had and those who had not completed SSCiGP training. In all, 222 questionnaires were distributed. Initial response rates were poor (22%) but improved slightly following a reminder (33%). Of the 73 returned questionnaires, 49 were from those who had completed the SSCiGP programme and 22 from those who had not (two respondents did not answer the question about attending). This low response rate is reflected in previous national self-care evaluations that have encountered difficulties in recruiting significant numbers of healthcare professionals (White *et al.*, 2008).

Data analysis

Analysis of all qualitative (interview and case study) data was completed using thematic analysis. All data obtained were first fully transcribed and entered into NVivo 8 software to aid data management. Two members of the research team then completed a process of first-level (predominantly descriptive) coding of data, based mainly around questionnaire topic areas, then further second-level (predominantly analytic) coding. A process of agreeing how these first- and second-level codes related was then undertaken by two team members and codes were clustered together to form appropriate themes (Miles & Huberman, 1994). In addition to the specific themes, phase 1 identified five important domains (Table 1) that could be best used to inform data collection for phase 2.[3] In phase 2, these domains provided the overarching framework under which the qualitative interview data codes clustered, and both first- and second-level coding was completed within these theme headings.

Data from the questionnaires were inputted into PASW (a statistical software package), cleaned and transformed into single construct scores using underlying principles outlined in Francis *et al.* (2004). In order to assess whether there were differences between individuals that had completed the SSCiGP training and those that had not, *t*-tests or χ^2-statistical tests were performed.

Ethics

The study proposal was reviewed by a Local Research Ethics Committee chair and was assessed as constituting an evaluation that did not require full NRES system approval. The proposal was then approved through the Leeds Metropolitan University's Faculty ethics review process.

Findings

Given the complexity of the evaluation design, and the known difficulties of presenting case study reports (Yin, 1994), we have focused here on presenting integrated findings from both phases that relate to two main goals of the SSCiGP programme. First we focus on clinician change; shifts

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[3] A specific aim for phase one was to identify appropriate measures and indicators to guide data collection in phase two.

in thinking and in actual modes of engagement with patients. Second, we discuss practice level changes, which refer to modifications of systems, processes or philosophy within the surgeries.

Clinician changes

Not surprisingly, given the SSCiGP programme focus, following training clinicians mentioned changes in both their perceptions of self-care and how this influenced actual practices within the consultation.

Clinicians talked about adopting a more empathic, patient-centred approach to consultations, being more mindful of patients' priorities, understanding more about why patients engage in behaviour which is potentially harmful to their health and appreciating this within the wider context of a patient's life. They more frequently recognised that patients could generate their own solutions to health concerns, were more confident in addressing potential behaviour change within consultations and generally reported a more positive outlook on patients' ability to change:

'*I think it re-enthused me to try and explore with some patients what the barriers are to behavioural change. My attitude, I'm afraid had become increasingly, "well if they had been drinking heavily for thirty years or smoking or whatever, then nothing I say or do is going to have much impact". But, now, I'm exploring with patients what their beliefs and expectations are […] So it's coming at things from a very different standpoint*'

(GP)

These changes in perception generated adaptations in practitioner–patient dynamics within consultations as clinicians focused more on patient agendas and priorities. Clinicians reported taking more care with language and phrasing, using more open questions and the importance of listening skills and knowing when to listen. They talked about developing additional skills in gaining patient 'buy-in' to behaviour change by introducing tools such as the 'one-to-ten' readiness to change scale to motivate patients to consider what is important to them and why. This facilitated co-working with patients to set achievable action goals appropriate for the individual patient's personal circumstances. Some practitioners wrote these

action plans into the consultation notes so they could be revisited and so colleagues were aware of work done with patients. These changes in perception and actual practices were not separate but were integrated in clinicians' accounts suggesting that they are contingent on each other and work synergistically:

'*My practice has changed, I'm more aware of the patient's contribution. The plans that we put for them regarding lifestyle changes should be something which a patient can agree on doing. It should be practical for a patient and possible, otherwise it will not happen, if you just dictate a solution to them it's not gonna happen*'

(GP)

'*I think it's mainly trying to see the situation with the patients' eyes and to be sensitive to their agenda which sometimes might not be the same as your agenda*'

(GP)

'*This way of consultation allows… you probe more with the patient, you probe in more detail and therefore you get the patient to come to the decision rather than yourself and they're more likely, I feel, to take that on board. If they've taken that decision they are more likely to carry out what has been agreed*'

(GP)

For many clinicians, particularly the GPs, these changes in practice were seen as 'small', 'incremental' or 'additions' to skills already previously acquired.

Importantly, these changes in clinician perception and practice resonated with what patients considered important from their consultation interactions with clinicians. In particular, patients highlighted the importance of friendliness of staff (approachability), being listened to, and being recognised as an individual:

I: '*When you have a consultation, how do they introduce the advice, what kind of things do they say?*'
P: '*Well, I don't know how to start with that one. It depends on what problem you've got and they always listen to you first, and then the advice, you know, "I think this is the best*
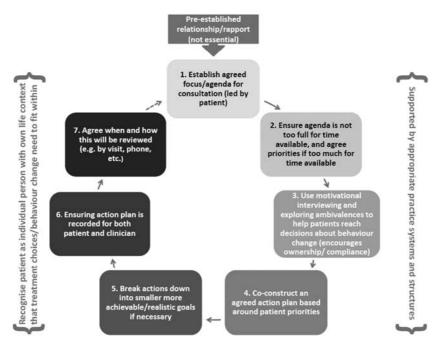
Figure 1   The 'ideal' consultation

way to go round it". So yes, they listen to you
first and then they'll advise you'

(Patient)

'*I get the feeling that they're really, really
interested in me. And they'll talk to me,
which is good. You feel as though you're not
one of a crowd, that you are the one that they
wanna talk to*'

(Patient)

Some patients directly recognised that having
these values and skills, when present across the
whole practice, acted to promote self-care:

'*I think the aura of the practice, the ethos,
makes you believe that the practice is a
patient-caring practice, and I think that helps
to self-motivate your own personal self-help*'
(Patient)

What emerged from this data around clinician
impact and patient views is that, following the
SSCiGP programme, there are several compo-
nents that fit together to make up an 'ideal con-
sultation' and these are presented schematically
in (Figure 1).

There were no statistically significant differences
in any of the quantitative indicators between prac-
titioners who had attended the SSCiGP training
compared with those who had not. For example,
attitudes (possible scores minimum = 42, max-
imum = 119) towards facilitating self-care were very
positive, although there was no difference between
SSCiGP attendees and non-attendees (mean =
96.43 versus mean = 99.10, $t = 0.42$, $P = 0.68$).
Similarly all practitioners' self-reported self-care
behaviour was relatively high (possible scores
minimum = 8, maximum = 56), although again
there were no statistical differences between
SSCiGP attendees and non-attendees (mean =
39.10 versus 36.44, $t = -1.40$, $P = 0.17$).

However, the qualitative data do suggest (at
least rhetorical) differences between the two
groups. Empathy was mentioned very briefly in
only one of the interviews with clinicians who had
not been through the SSCiGP programme and
no mention was made in any of these interviews to
managing change or treatment compliance within
the context of patients' own lives, or to shared
decision making. All six of the untrained clinicians
focused almost exclusively on the importance of

helping patients understand their condition and how to manage it and having good clinical knowledge and communication skills to do this:

I: '*What kind of skills do you think you need to make that empowerment?*'
P: '*I think it comes down to having good communication skills as a doctor, as a health care professional, to explain to the patient so that they have a good understanding of their condition. It comes down a lot to trying to educate them*'
(Nurse, not yet completed the programme)

This seems to represent a conceptual difference in how 'communication' is understood and practiced between the two groups. For those that have not completed the programme, the emphasis is on communicating knowledge and information *to* the patient. For those clinicians that had completed SSCiGP, while transfer of information remained important, the emphasis was very much on communicating *with* patients, exploring their condition and possible behaviour change within their own context, so they can make informed decisions that are relevant to them and their life.

Despite the positive changes reported by the majority of those who had completed the programme, there were also barriers that were recognised as limiting the implementation of learning from the programme into consultations. The most significant barrier related to the time available during consultations. This was noted by all of the clinicians and was seen to be particularly responsible for reverting back to 'old' consultation styles that de-centralised the patient and their agenda when practices were under pressure:

'*It's really important for clinicians to have skills of keeping every individual patient at the centre of that consultation. It's very easy as a clinician to tell the patient what they think they need to do or need to know because it's in – ten minutes – out. I guess it's very tempting in a busy surgery to deal with the problem by telling the patient what to do, what to decide, what to take, or how to behave, rather than putting the patient at the centre*'
(Other practice staff)

The importance of time, and how this links to the focus of the consultation and whose agenda is

driving the consultation, was also recognised by some patients:

'*At the end of the day it boils down to how long a nurse or a doctor's got. See that's the hold up, by the time you've talked about your problem, there's no time for them to do it, it's not their fault*'
(Patient)

Clinician reluctance to alter consultation styles was a further reported barrier to change:

'*There are some members of the team who just didn't get it, despite attending three sessions, and still would not use appropriate language, and still would not… but this is only one individual out of quite a large team*'
(GP)

Linked to these barriers was recognition that wider practice systems and structures needed to support the implementation of these skills within consultations and help the movement towards the 'ideal consultation'. The survey showed that two-thirds of the clinicians perceived that practice systems did not facilitate self-care. However, clinicians from practices who had completed the SSCiGP programme were more likely to agree or strongly agree that their practice systems did support facilitation of self-care compared with those who had not completed the programme (48% versus 28%). This being the case, we now outline some examples of where the SSCiGP programme made impact on practice systems in ways that sustained learning at the consultation level.

Practice changes

Practices that had completed the programme had implemented various changes to processes and structures that helped facilitate use of the SSCiGP skills within consultations. Many of these changes were being considered before commencing the programme but the programme gave greater drive, urgency and legitimation for practices to begin to implement these. At its most basic, the aim was to create longer consultation times to make best use of the patient-led, patient-centred skills learnt:

'*You'll have noticed, we've introduced routine 15 minute appointments [in the morning surgery]. That's partly an acknowledgement*

of the impossibility of doing motivational work with patients within the constraints of conventional 10 minute consultations. I think that's certainly improved my professional quality of life because it's made it much more satisfying for me and I think from the patients' point of view, hopefully, it's better for them'

(GP)

A variation on this was to offer specific patients (predominantly those with long-term conditions) an opportunity to book 'double' (20 min), or even 'triple' (30 min) appointments. This was facilitated by adjusting the practice computer system to place an 'alert' on patient records so that administration and reception staff knew that this person might require a longer appointment.

Yet, creating longer consultation times in these ways obviously requires other changes to be made to facilitate this. Some practices dispensed with separate disease specific clinics. Recognising that many patients with long-term conditions have multiple pathologies, one way to reduce repeated scheduled visits was to bring such patients into a single long-term condition clinic with longer appointment times. Shifting the skill mix in provision of services was also commonly used to create longer consultations. These shifts had to be well thought through to ensure that patients were seen by the most appropriate people, so clear care pathway system planning was required:

'We've had changes to the skill mix within our clinical team. The health trainer is supplementing and complementing our team nicely and we've trained our health care assistant to assist the practitioner so she is now able to see our diabetic patients for hypertension review, so the pathway's changed slightly. It might previously have been with the nurse or with the doctor, now we've put in another strand there. We've got an assistant nurse practitioner and she's a great asset to our team. So the pathway's changed that way'

(Other practice staff)

There was increased use of telephone contacts within case study practices that consisted of increased telephone triage (for surgery appointments and/or home visits) for both minor illness and in more acute situations:

'If someone wants an appointment sooner than the next available we will phone them and discuss appropriate management. An awful lot of those that initially want appointments we manage over the phone and encourage self-management of minor viral illnesses etcetera. We often get patients who phone up who are offered an appointment who would rather have a phone call because it's more convenient to them and they are used to it'

(GP)

In addition to this, one practice operated a 'virtual clinic' for reviewing some long-term condition (diabetic) patients and this was seen to actively facilitate self-care (Figure 2).

Ultimately, shifting practice systems and structures very much depended on the ability and willingness of practices to address the challenges of change:

'If there's something that's not quite delivering, be brave enough to slightly dismantle it and try something else and I think one of our philosophies is that we are willing to do that'

(GP)

This links to SSCiGP programme aims to help generate a coherent whole practice ethos and commitment to supporting truly patient-centred approaches and the systems that are required to make them effective. The importance of this was recognised particularly by practices that were early adopters of the programme:

'If there isn't a whole team approach I think you can more or less forget it because no clinician will practice like this in isolation. It has to be a philosophy of the practice. It has to eat through everything for us all to continue to be brought in to it. It becomes part of the way that… the whole practice philosophy is the way we deliver services'

(Other practice staff)

To make this whole practice approach a reality, this practice trained reception and administration staff in supporting patients with long-term conditions.

> "In the diabetes clinic, they see the health care assistant, they're assessed, their parameters are measured and blood is taken. They are then booked into a virtual clinic where I plough through fifteen, twenty sets [of results] in an hour, looking at the results, the assessment that the HCA has done, any comments the patient has made. I then create a letter which says "yes, everything's fine carry on, see you in six months, if there is anything you wish to discuss please feel free to make an appointment." Or I might say "come and see me" or "get this checked in three months." With some patients who I know are on the self-care route, I might write and say "I noticed your blood pressure was a little bit up, I suggest we start this tablet, I enclose a prescription, try it, if you've got any problems come back otherwise get your blood pressure checked in a month and we'll see how it's going." It saves the patient a lot of time when a patient comes in, sits down, I say "how can I help?" they say "I came for my diabetes results" I say "they're absolutely fine" and they say "oh thank you doctor" and get up and walk out which feels like a waste of both of our time. The letter is a way of keeping the personal touch as they know I have looked at the results. And it's interesting the feedback we've had, I thought there'd be a lot of resistance to it but there hasn't been. We trialled it, what we were interested in was whether results would deteriorate because of that lack of contact. Actually they haven't at all and in some cases patients' control has improved since we have done this, I think because they feel much more that it is *their* responsibility."

Figure 2   Effective review of long-term condition (LTC): a 'virtual clinic'

This consisted not only of the practical skills and computer systems involved but, more importantly, was premised on developing empathy, enhanced listening and communication skills and demonstrating appreciation of the difficulties such patients might face.

Finally, but perhaps most importantly, developing this whole practice ethos by its very nature requires good engagement of patients within the practice. One practice further developed its relationship with the patient participation group around the same time as completing the SSCiGP programme seeing these processes as 'working in tandem'. Working on what the practice manager called a 'bottom-up' principle, all changes were developed in consultation with the very active patient participation group to get feedback and to continue to try and improve service delivery. This group has also recently '*set up a small hub for self-help groups for patients with long term conditions*' (Other practice staff), to provide additional information and support around self-management.

Discussion

It is clear from this evaluation that effective change in relation to self-care often requires shifts in clinician perceptions and practice level culture, as well as the provision of specific skills and tools that help clinicians better engage with patients around self-management and behaviour change. Indeed, developing the right 'philosophy' at both individual clinician and practice level was seen as fundamental to generating a sustainable approach to self-care and behaviour change that complemented other regional and national initiatives, such as the Expert Patient Programme and work around Personal Health Planning.

The changes reported here by the clinicians are factors that have previously been recognised as

beneficial to improving consultations and patient satisfaction. Partnership-building dialogue, including verbal and non-verbal empathy (eg, using 'we' instead of 'I' or 'you' when referring to actions), shared decision making which respects patients' values and preferences, and considering how health problems impact on patients' daily living (Beck *et al.*, 2002; Moran *et al.*, 2008; Ruiz-Moral, 2010) have all been demonstrated as important aspects of clinician–patient interactions. The information provided suggests that clinicians who had been through the SSCiGP programme and patients in those practices had developed good agreement on these issues and the respective roles they fulfil to facilitate an 'ideal' consultation. This reflects previous research (Stewart *et al.*, 2000) that recognises how finding common ground is key to patient-centredness within a consultation and is related to better outcomes on a variety of measures (mental health dimensions, fewer diagnostic tests and fewer referrals as well as lower levels of post-encounter discomfort and concern). Likewise, Wagner *et al.* (1996) recognised that 'collaborative problem definition' and joint 'goal setting' were two key components for supporting self-care. More recently, the King's Fund review of patient engagement (Parsons *et al.*, 2010) found that shared agreement and understanding of patient and clinician responsibilities was a key domain in enabling successful engagement in primary care consultations. The importance of programmes such as SSCiGP, that have the twin focus of facilitating a patient-centred perception as well as developing specific consultation skills around this, should therefore not be underestimated in their potential for ensuring that clinicians are prepared to move forward with self-care agendas that reflect patient needs and desires.

However, having adequate time to utilise patient-centred approaches within consultations represented a challenge and this has been recognised as a significant issue in the previous national Self-Care in Primary Care study (White *et al.*, 2008) and in a recent review of patient engagement (Parsons *et al.*, 2010). Clinicians were clear that to fully utilise the learning from the SSCiGP programme required the support of practice level systems and structures. As others have shown, general initiatives to support self-care are more likely to succeed when they are fully integrated into the delivery of general medical services within a practice (Chambers, 2006). Specifically, some have spelled out how attention needs to be given to developing practice information, referral and review systems, and staff awareness of the interventions available to maximise self-care support (Greaves and Campbell, 2007). Evidence here confirms that the development of individual skills to support self-care is more likely to be effective and sustained when clinicians have time within consultations to put these into practice. This in turn often requires changes to practice systems and structures to facilitate and generate this time. In particular, the opportunity to have sufficient consultation time to utilise patient-centred and motivational approaches to condition management and behaviour change (which itself can be supported by shifting skill mix, use of telephone consultation/review and staff training) is vital to success in an environment of highly competing demands. Previous work (Greaves and Campbell, 2007) has shown that developing such self-care systems requires the full support of the primary health care team. We would further suggest that this 'full support' is not only about system change but most importantly relates to the development of a shared ethos and set of values in relation to self-care. It was notable, rhetorically at least, that the skills learnt through SSCiGP were more commonly recognised as forming part of a 'normal' consultation in those practices that also made regular reference to the importance of taking a whole practice approach to supporting patient-centred systems.

It is clear that current NHS service configurations are not adequate to fully address what those at the forefront of improving quality and efficiency for long-term conditions in the NHS have called the 'tsunami of need' (Dillner, 2011). This evaluation demonstrates that training around clinician change can be effective in shifting service delivery, but only if sat within a cultural framework that genuinely situates patients at the centre of consultations and practice level activity. Furthermore, caution needs to be applied following this evaluation. The data presented are all self-reported and is not therefore a direct measure of whether changes actually did occur or, importantly, if they did whether they were sustained. There was limited evidence from the survey that there were significant differences between those who had and had not completed

the SSCiGP programme. There may be several reasons for this. First, the sample size is relatively small (particularly of those who had not yet completed the programme) so while there may have been differences between the groups it was not possible to pick this up at a level that is statistically significant in the survey. Second, it could be due to an effect predicted by a model of innovation of diffusion (MacDonald, 2002) where new innovations (in this case the SSCiGP programme) are more likely to be adopted by those that have positive attitudes towards the innovation. This is supported by findings here, as the survey showed positive attitudes to self-care values and practices were reported by most clinicians – both trained and untrained – who had signed up to participate in the SSCiGP programme. This may indicate that both groups already demonstrated a high level of commitment to self-care even before the training, so changes made following the programme might be statistically small but still practically significant. Third, it may be that training does not lead to any further quantifiable improvements in attitudes or behaviour for an already committed group of clinicians. Given that those practices most likely to be attracted to the SSCiGP programme were also those who, philosophically, were already inclined towards being patient-centred, further research would need to be completed to ascertain if and how this might be achievable across different types of practices.

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