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FINAL REPORT

An evaluation of the Working in Partnership Programme Self Care in Primary Care Initiative

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1

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Table of contents

Executive Summary

Research Summary

This evaluation followed the implementation of a training package for health professionals to introduce Self Care into four pilot Primary Care Trusts (PCTs) across England. The project was delivered during a time of reorganisation in primary care, with many competing pressures on PCTs and Practices.

Key finding:

- The primary outcome measure of a reduction in usage of primary health care services as measured by GP consultations in frequent attenders comparing the 6 months prior to study to final 6 months of the study period was not demonstrated.

Other main findings:

- The initiative was welcomed by PCT and Practice based stakeholders but recognised as a cultural change from the way the NHS currently operates.
- Both patients and staff reported that they were already engaged in self care activities, but there was wide variation in definitions and understanding of self care, not all of which fit the proactive concept of self care that the SCinPC initiative aimed to embed.
- The introduction of Self Care in Primary Care (SCinPC) into the Practices has been problematic due to other competing priorities, and therefore patchy and unsustained.
- The training programme has resulted in many Practices scrutinising their current working practices and making changes to the way they analyse and manage their workload.
- There were no significant differences between the comparison and intervention group patients in degree of change in perceived well-being and other psychometric measures.
- Qualitative interviews with patients did not reveal any change in self care activity over the follow-up period.

The Research

There were three components to the study, which followed patients and health professionals over a 12 month period following the introduction of the training packages:
- Qualitative interviews with health professionals and key stakeholders within the PCTs and baseline and exit questionnaires with the health professionals in intervention Practices.
- Qualitative interviews and questionnaires with patients identified as frequent attenders in pilot Practices within the PCTs.
- Analysis of routinely collected data on usage of health services by those patients recruited into the study.

Patients were recruited from intervention and comparison group Practices.

A total of 1454 patients were recruited onto the study, 746 in the intervention group and 708 in the comparison group.

Findings

Implementation of Self Care into the Practices

- The aims of the initiative were felt to be important by PCT and Practice based stakeholders.

- The initiative was felt to complement the NHS drive to increase the health of the population through greater use of self care, but at the same time was seen as a shift from the way the NHS currently operates.

- Changes were felt to be needed both with the public and at all levels of the health service to ensure matched knowledge and awareness of their place in the changing culture.

- The PCTs were supportive of the initiative.

- SCinPC had limited buy-in at the Practice level leading to minimal implementation within Practices.

- There was difficulty reported in finding time / incentives for Practice staff to attend workshops and implement changes due to other competing priorities.

- There was a mismatch between the expectations of the Practice staff and those developing the training package, with Practice staff wanting more prescriptive training.

- There were problems of follow-up, leading to a feeling that the programme 'fizzled out'.

- The current culture does not encourage change in either content of patient/ GP consultations or patterns of consulting.

- There is disagreement among primary health care professionals and Practice staff as to whose role it is to support self care.

- The majority of primary health care professionals reported that they were already engaged in supporting self care.

- Demand management/triage was often seen as the implementation of 'self care' and it is here that most of the activity seemed to be focused.

- There was acknowledgement of the need for further training/education across the board.

- There was no evidence that GPs changed their consultation style to promote self care.

Impact on Patients' self care

- The primary outcome measure of a reduction of 20% in usage of primary health care services as measured by GP consultations in frequent attenders comparing the 6 months prior to study to final 6 months of the study period was not found.

- *Secondary outcomes:* No significant differences between patients from intervention and patients from comparison group Practices with regard to questionnaire findings after 6 or 12 months.

- Patients were already generally confident in their ability to self care, but there was wide variation in understanding of the concept of self care and what it involves.

- Patients were largely unaware of changes within the Practice. The appointment system was commonly reported as having changed (specifically triage) however this cannot be attributed specifically to ScinPC.

- Most patients had not been given self care advice, or were unaware of being given self care advice from anyone at the Practice.

- Patients were concerned about continuity of care and accessibility of primary care services.

- The majority of patients saw the GP as the first port of call for health support.

Conclusions

This was the first attempt to introduce a change within primary care that would have an effect on the GP consultation itself. It was recognised that the successful introduction of self care into primary care required the very culture of GP practice to alter and this was a challenge that would take more time and resources than this current pilot could call on.

For the initiative to be successful, changes needed to be made at organisational level, at consultation level between primary health care professionals and patients and ultimately in individuals' behaviour, both of professionals and patients. There were attempts made in some Practices to initiate changes but these seemed to relate more to demand management issues rather than supporting the development of self care within individuals.

No significant changes were seen in study participants' use of health services, psychometric scores or self care beliefs or behaviours during the course of the study.

There was however strong support at PCT level for the aims of the initiative, and at Practice level many primary health care professionals and Practice staff could see the potential benefits of the initiative.

1.   Introduction

1.1   WIPP Self care interventions

With the negotiation of the General Medical Services (GMS) contract for General Practitioners, there came a commitment to support self care. That is, to identifying, first, ways in which the public could be encouraged to be proactive in taking care of themselves and their health and to use healthcare services more effectively, and, second, where these services could be offered by other health professionals, especially where these services could be accessed more easily and more cost-effectively than through traditional general practice (Department of Health 2004; 2006).

The remit given to the Working in Partnership Programme enabled the development strategies and projects to support self care in mainstream services and to pilot how best to support individuals within their own communities. The Self Care in Primary Care initiative (SCinPC) aimed to enable healthcare professionals to support their patients to self care. The Self Care for People initiative (SC4P) aimed to provide skills to enable the public to self care. These two initiatives are complementary. Leeds Metropolitan University also carried out a separate evaluation of SC4P and on the site with both interventions (Bradford tPCT) to assess 'Self Care in Action'.

1.2   The Self Care in Primary Care (SCinPC) initiative

The Self Care in Primary Care initiative (SCinPC) offered a practical guide for Practices, Primary Care Trusts (PCTs) and other care agencies to help embed support for self care in primary care. The Self Care in Primary Care training package, which was developed by Staffordshire University, included workshops and tools to help develop a Practice-based strategy and training skills programme that supports self care, and gave practical examples of how self care can be delivered (Chambers 2006). The training was designed with the intention that Practices would take ownership by identifying the areas they viewed as needs and priorities for the Practice. The intention was that Practices would work on specific topics and learn ways of working that could be transferred to other topics in the medium and longer term. The training would be cascaded by those who attended the workshops to those who did not attend. The main aims of the SCinPC initiative were to further develop key self care support skills for primary health and social care professionals, improve the understanding of NHS policies around self care, and facilitate the development of a locality-wide strategy to support self care.

The SCinPC initiative was piloted in three PCTS; Bradford, Central Cheshire, and Lambeth and Southwark. Primary care Practices (hitherto referred to as 'Practices') who took part in the initiative received three three-hour workshops delivered by facilitators who where either from the PCT or the private sector. The workshops were held over a period of three to six months and all Practice staff were encouraged to attend; to facilitate this most workshops were held in protected learning time.

SCinPC was not about research subjects passively being given an intervention but about professionals and patients being actively engaged in the process of self care. The different stages of change in patients and the links between those stages and the desired outcome of reduction in unnecessary GP consultations can be modelled hypothetically (Figure 1.1).

Figure 1.1 Theoretical model of intervention effects

Primary Healthcare Professionals (PHCP) participation in training etc

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increased knowledge and skills

↓

confidence to undertake self care discussions with patients

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support to enable patients to self care

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patients' intention to self care

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changes in patterns of service use
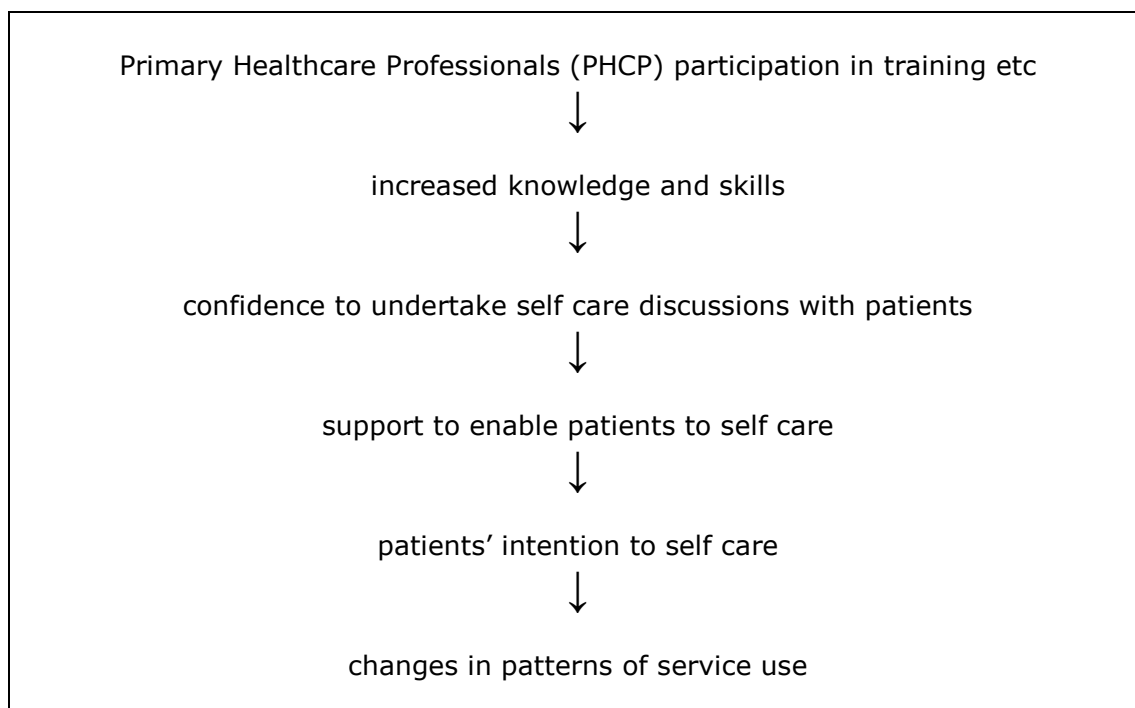
1.3   Structure of Report

This document reports the findings of the evaluation of the pilot phase of the WiPP Self Care in Primary Care initiative. The report comprises:

- outline of the research methods;
- a process evaluation of the implementation of SCinPC, from the points of view of stakeholders and primary healthcare professionals;
- evaluation of the impact of SCinPC on PHCPs and Practice staff;
- qualitative analysis of patients' perspectives on self care, support around health care decision making, and relationships with primary health care professionals;
- evaluation of the impact of SCinPC on patients over a twelve month follow-up period, comprising:
  - o analysis of changes in health service use,
  - o analysis of changes in psychometric and health literacy scales, and
  - o qualitative perspectives on the initiative.

This is a short report. A review of relevant literature and a discussion of findings, along with further details of methodology and findings, can be found in the Appendices.

2.   Research methods

2.1   Aims and objectives

The aims of the study were to evaluate the development and implementation of the SCinPC initiative and to assess its effect on primary health care professionals (PHCPs) who participated in the initiative and their patients, and its impact on the local health economies, over a period of one year. The research programme consisted of three major elements:

(i)   Quantitative and qualitative research with frequently attending patients (see section 2.5 for definition of 'frequent');
(ii) Quantitative and qualitative research with PHCPs and Practice staff;
(iii) Assessment of the impact on service utilisation and local health economies.

These three elements measured specific aspects of the SCinPC initiative; however an integrated approach was adopted for the conduct and reporting of the research. The overarching research questions for the study were as follows:

▪   What impact does the SCinPC initiative have on patterns of self care and service utilisation on the part of patients?

▪   Does the SCinPC initiative lead to a reduction in General Practice workloads?

▪   Does this initiative lead to changes in primary healthcare professionals' knowledge, attitudes and beliefs relating to self care?

▪   What impact does the initiative have on the health economy and culture within Practices and the PCT?

▪   What changes can be seen within the target population in relation to their self care activities, beliefs and healthcare behaviours?

▪   What changes can be seen within the target population in relation to health outcomes?

▪   Is the SCinPC initiative feasible, relevant, appropriate and acceptable to major stakeholder groups?

▪   What are the facilitating factors and barriers that influence the process of successfully implementing, embedding and sustaining the SCinPC initiative?

The approach and design of the evaluation were informed by the nature of the intervention and the primary health care settings in which it was implemented. The research design was quasi-experimental, allowing comparison between patients from Practices (termed 'intervention Practices') receiving the multidisciplinary training package and patients from Practices ('comparison group Practices') that were not. The evaluation was longitudinal, allowing comparison over time by tracking changes in both the PHCPs and the patients targeted by the SCinPC programme. The research design also used triangulation by drawing on data from different methods and data sources, thereby strengthening evidence.

The primary outcome measure was a reduction of 20% in usage of primary health care services as measured by GP consultations in frequent attenders comparing the 6 months prior to study to final 6 months of the study period.

2.2   Research with frequently attending patients

Structured postal questionnaires (see Appendix 2) were sent to frequently attending patients (see section 2.5 for definition) at baseline, 6 months and 12 months. The questionnaires incorporated items from standardised psychometric measures of anxiety, perceived stress, self-esteem, self efficacy, recovery locus of control, subjective well being and reported health status. These were chosen to capture the potential range of changes that could take place at the individual level, whether or not a change in service use was seen. Demographic information, and information about patterns of service use, sources of health advice, health literacy, confidence to self care, future intentions to self care and exposure to self care initiatives and resources were also collected.

Qualitative, semi-structured telephone interviews were conducted with 80 study participants from intervention Practices who volunteered to be interviewed. Interviews were conducted at baseline, around 6 months and at 12 months to allow changes to be tracked longitudinally. Interview schedules were used to elicit information on key aspects including interactions with PHCPs, changes in the Practice, changes in service use, access to sources of support and other health and social outcomes.

2.3   Research with Primary Health Care Professionals

Quantitative research was planned to include all PHCPs and other NHS staff who received the multidisciplinary training (MDT) package. An initial questionnaire (see Appendix 3) was administered during the period between a Practice being recruited onto the programme and the first training workshop. Subsequently, postal questionnaires were administered at 6 months and 12 months. These focused on beliefs and attitudes towards self care, role and activities in general practice and perceived value of the MDTP. Due to the low response rate to these questionnaires, a shorter exit questionnaire was sent to all members of staff in all the intervention Practices at twelve months.

Semi-structured interviews were carried out with a sample of PHCPs and staff from each of the intervention Practices. The sample was selected to ensure that a range of roles and professional backgrounds were included in the study. The purpose of the interviews was to determine their views of the initiative and their experiences in supporting self care within routine practice. An interview schedule was used to elicit information on satisfaction with the programme, barriers and facilitating factors, changes in service use, access to sources of support and other health and social outcomes.

2.4   Research on the impact on local health economies

Routinely collected data were used to assess the impact of the initiative on the use of primary care and acute services. The primary outcome measure was a reduction in GP consultations, comparing the 6 months prior to entry into the study to the final 6 months of the study (i.e. the same six month period, one year apart). Anonymised data was collected for each study participant on service use including:

- Consultation rates with:
    - GP
    - other health care professionals in the practice;
- Out-of-hours service use;
- A&E visits;
- NHS Direct use.

Routine data collection protocols can be found in Appendix 10.
Quantitative routinely collected data from the four PCTs was aggregated by Practice and analysed using statistical modelling in SPSS 15.0 and MLWin 2.02.

In addition to the routine service data, qualitative semi structured interviews were used to examine process issues arising from the development and implementation of the initiative in the three intervention PCTs.

2.5   Population and sample size

A key component of the need to promote and support self care by primary health care professionals is the issue of the number of frequent attenders that are using the services. For the measurement of change in the evaluation of the SCinPC initiative, we chose to focus on frequently attending patients, for the following reasons:

(i)   Patients who attend their Practice frequently would seem to be the most likely to experience any changes brought about in the Practice by SCinPC over the relatively short follow-up period of 12 months.

(ii)   Frequently attending patients are more likely to show a difference in the primary outcome measure (GP consultation rates) over the course of 12 months than the whole Practice population, which would include people who attend infrequently. There is more potential for change in the frequently attending group.

The sample was drawn from those people who were identified as higher users of health services (8 -11 consultations in a year) and included men and women aged 16 years and over. A pilot study carried out in one of the participating PCTs indicated that targeting this group should give sufficient numbers of potential study participants.

Exclusion criteria were:

▪ Those with a terminal illness or receiving terminal care
▪ Pregnancy
▪ Severe mental illness

A protocol for selection, recruitment and consent procedures for the study was drawn up in consultation with the SCinPC steering group and PCT leads. Each participating Practice identified people meeting the study criteria by means of an electronic system search. In some Practices the search was carried out by Practice staff and in some an IT company carried it out. Practice managers were given discretion to exclude other potential participants from the sample if they were considered to be unsuitable for the research, for any reason.

Sample size calculations were carried out using the primary outcome of reduction in GP consultation rates in the last six months of the study compared to the six months before baseline. An estimated effect size of 20%, gave a required sample size of 250 participants in each group (intervention and comparison group) at the end of the twelve month follow-up period. To allow for an estimated 30% dropout at six months and a further 30% at twelve months follow up, a minimum of 510 people needed to be recruited into each group (intervention and comparison group) at baseline.

There were 1454 participants (patients) who returned a completed questionnaire: 746 from intervention Practices and 708 from comparison group Practices. At six months, 1454 questionnaires were sent out and 1041 were returned, giving a retention rate of 72% (71% in the intervention group and 73% in the comparison group). At twelve months, 1404 questionnaires were sent out (to all baseline study participants, minus those who had died, moved away or asked to be withdrawn from the study) and 1018 were returned giving a retention rate of 73% (74% in the intervention group and 70% in the comparison group) or 70% from baseline.

Eighty participants (patients) were interviewed at baseline. At six months, only those participants who had been to the GP Practice in the previous six months (fifty-two participants) were re-interviewed. At twelve months, 50 participants were interviewed.

2.6   Ethics

Ethical approval and R&D contracts were obtained for the study. In line with the proposal submitted to both committees all those involved in the study gave their consent for inclusion (Appendix 4).

2.7   Intervention and comparison groups

Four PCT areas and 11 Practices were involved in the study:
- Two PCT areas undertaking a single programme (SCinPC) – Central Cheshire (now Central and Eastern Cheshire) (4 Practices) and Lambeth & Southwark (4 Practices)
- One PCT undertaking two programmes (SC4P and SCinPC) – Bradford North & Airedale (now Bradford) (2 Practices)
- One PCT undertaking neither programme, which is acting as a comparison area for Bradford North and Airedale due to the potential for contamination of comparison group Practice participants, who might have been exposed to the Self Care for People initiative – Leeds West (now Leeds) (1 Practice)

More details about the PCTs taking part in the initiative can be found in Appendix 5.

Intervention group:
- 2 Practices from Central and Eastern Cheshire PCT;
- 3 Practices from Lambeth and Southwark PCTs;
- 2 Practices from Bradford tPCT

Comparison group:
- 2 Practices from Central and Eastern Cheshire PCT;
- 1 Practice from Lambeth and Southwark PCTs;
- 1 Practice from Leeds PCT

3. Process evaluation of the implementation of SCinPC

Summary of key findings

Stakeholder perspective

- This initiative was felt to complement and assist the NHS drive to increase the health of the population through greater use of self care support, however it was seen as a shift from the way the NHS currently operates.
- There were competing pressures on PCTs and Practices due to the reorganisation of primary care.
- For the initiative to work, changes were felt to be needed to inform the public and all levels of the health service of the changing culture and their place within it.
- The PCTs seemed to favour the initiative, but felt that it may be too early to see its effects.
- Practices found it harder to assimilate the necessary culture change due to:
  - Problems in running the training packages as envisaged due to the degree of commitment needed from Practice staff and mismatched expectations of the course content;
  - Perceived resistance among health professionals, particularly GPs, to change current ways of working.
  - Perceived resistance among patients to change current ways of consulting

Primary Health Care Professionals' perspective

- There was a limited response from the health professionals to requests for interviews or for completion of baseline or exit questionnaires.
- The majority reported that they were already engaged in promoting self care.
- Self care was seen as likely to be of benefit to most patients.
- Respondents to the baseline questionnaire could see a range of positive potential outcomes to the initiative including improved patient health, improved patient self esteem, and improved health services.
- Many positive effects of the training programme were perceived, including the opportunity to work as a team and examine current practices and ways of working.
- Most activity was focused onto setting up triage systems.
- There was little evidence suggesting that GPs were prepared to engage with the broader self care agenda.

3.1 Stakeholder perspective

Four PCT leads, five Practice Managers, three trainers/facilitators and five other PCT staff were interviewed between six months and one year after the SCinPC workshops began. Many of those involved at Practice and PCT level had done previous work on long term conditions and/ or patient public involvement or health inequalities.

Table 3.1   Stakeholder interviewees

Role:	PCT:	Bradford	Lambeth & Southwark	Central Cheshire
PCT lead		1	2	1
PCT staff		2	0	3
Practice Manager		2	1	2
Trainer/ Facilitator		1	1	1
Total		**6**	**4**	**7**

3.1.1   Context

- The general impression was that the Self Care initiative complemented and assisted the work of the NHS well, and fitted in with the health strategies being promoted by the Government. At the same time, self care support was seen as a shift from the position the NHS had held since its inception:

"there has been a real shift over time if you look at the way health care was delivered. Probably 10/15 years ago it was really very much about putting your body in the hands of an expert and it being mended and given back to you. You weren't expected to ask questions about the treatment that you were receiving; you weren't expected to inform yourself about it, you weren't expected to challenge the options that you were being offered." PCT-based stakeholder, Bradford

- The stakeholders felt that the aspiration of the initiative was laudable, and there was praise for the book accompanying the training.

3.1.2   Delivering the Multidisciplinary Training Package

- There were difficulties in getting access to the Health Centres and arranging the sessions with the GPs:

"Most of the barriers with delivering the training have been GPs saying they are too busy or don't have the resources. Just getting into a GP Practice is difficult in terms of the bureaucracy." PCT-based stakeholder, Lambeth & Southwark

- To get senior Practice management together three times in three to six months proved difficult. Although they were using protected learning sessions, there was a problem in having to use three of the 11 sessions available on the same subject area.

- Those facilitating the sessions found that they had to adapt the programme to make it shorter and also to make it more appealing to the Practice staff, although the materials were designed to be flexible and easily adapted between Practices.

- The feedback the stakeholders were getting from the Practices was that they were expecting more of a 'how to' kind of training than discussions on the nature of self care as part of the package. The package did contain a number of 'how to' tools but interviewees did not mention these:

"… another Practice that said we can't do it in that [3 sessions of 3 hours] but you can tag on to the end of our Practice meeting. They gave us 20 minutes and that was fairly disastrous. What they didn't understand was that this was about them being given a framework within which they could consider how to increase the amount of work that they did in a self care type of way... it wasn't about going in and delivering a training session that says this is how you do self care." PCT-based stakeholder, Bradford

- It was important that the facilitators were confident enough to challenge the health professionals and had the ability to create the right environment to allow recognition of present practice and the kind of cultural change necessary for SCinPC to work.

- Many of the practitioners thought that they were already promoting and supporting self care:

"Some of the GPs realised they weren't self-caring [sic], even though they thought they were promoting self care, when they really looked at the model, they weren't promoting self care." PCT-based stakeholder, Cheshire

- The relationship with the external training organisation was quite challenging at the beginning and having a package that was not developed from practice, but from the 'centre' was a problem as that prevented Practice staff from engaging with enthusiasm and taking ownership of the training package. Some staff felt it did not reflect their everyday challenges.

3.1.3 Developing SCinPC in Practices

- Having time to consider self care with an external facilitator created a good environment to explore taken-for-granted assumptions about what self care support could be provided by them, and also to raise the profile of self care:

"… at the end we had a clear list of things that we were doing right, things that we could improve on and that we weren't doing right. Now that is something that unless [the] self care [initiative] had come along it would have been well low down our list, …It doesn't happen we never have any time but this actually gave us time. It was actually a real benefit because it gave us head work and it gave us time for everybody to get together." Practice-based stakeholder, Bradford

- There was a perception that there were many positive effects of the training programme, including an examination of current practices and how patients with minor ailments are identified and supported. Once Practices started to look at who the frequent attenders were and what other services could be offered to them, the way they saw their provision changed.

- SCinPC was seen as complementary to the work of a lot of community and voluntary organisations that deliver self care skills training programmes for people with long term conditions, such as the Expert Patients Programme (EPP). It was also perceived to complement the work of local governments, for example healthy walks and healthy lifestyles, as well as creating better links with Public Health initiatives.

- There was an impression that more patients were choosing to self care, but it was accepted that this is not easy to audit.

- There was some concern that it was 'not on the agenda' of community teams such as physiotherapists, specialist nurses etc.

- There was mention of a link with prescriptions as an indicator of why people frequently attended. One explanation was that people attended to get larger numbers of tablets than buy them over the counter.

3.1.4 Influencing factors

3.1.4.1 The role of GPs and Self Care

- The role of GPs in getting Self Care in Primary Care established was seen as particularly crucial:

"Interestingly some of the GPs that we've worked with have said themselves that they believe that they are responsible in part for not encouraging patients to self care, because obviously they're people who have come into a service and they want to be needed. … to actually hand control over to patients and lots of information to patients can potentially threaten their own value." PCT-based stakeholder Bradford

- Stakeholders reported that many of the frequent attenders stated that they keep coming back due to the doctor requesting to see them:

"The patients kept saying 'I don't want to keep coming in it's your doctor that keeps asking me to come in'. You need to tell your doctor if you don't want me to come in." (Practice-based stakeholder, Bradford)

- A new skill set was thought to be needed within the consultations to direct patients towards self care:

"… behavioural change is most powerful in a one-to-one setting. Motivation is an interpersonal process. If you hear yourself saying you're going to do something you're more likely to do it than if you just think it. There is no assessment of consultation style. From the focus groups with the patients, they said the one thing that would make them do what the doctor said was trust. How much do GPs know about rapport skills, questioning skills, building up trust? … They need something to enable people to assess their level of skills and to know what a really good consultation style is." PCT-based stakeholder, Lambeth & Southwark

- For Self Care to work the respondents felt that GP's needed to be more aware of health as a goal rather than treating illness.

- There was recognition that for some GPs patients with minor problems create a welcome relief within a busy case-load:

"The other thing is for the doctors that said the trouble is we get all these chronics in, people with really bad problems, so it's quite nice to have somebody come in with an ear ache or a sore throat. It's quite nice for that to happen; it gives you a 10 minute, 'phew that's nice'." (Practice-based stakeholder, Bradford)

3.1.4.2 Patients and self care

- From the stakeholders' perspective there was a concern that many patients expected to have direct access to their GP and did not like having to give information to the receptionist or being diverted to another health professional:

"There's still a cultural thing… people believe that seeing the doctor is the thing they want. When you offer them something else, whether to see the nurse or pharmacist or self care, people aren't nasty but they do believe it's a second best." Practice-based stakeholder, Cheshire

"The patients are still very dependent, particularly in deprived areas, the most important person to hear their diagnosis or to be reassured by is the GP." Practice-based stakeholder, Cheshire

3.1.4.3   Complexity/organisational constraints

- There was a feeling that this was a very complex project for the Practices to come to terms with and implementing the programme was more difficult than imagined due to the significant cultural changes needed:

"because the PCT can see the bigger picture but they're not the ones actually doing the implementing…" PCT-based stakeholder, Cheshire

- The development of a strategy to support self care was affected by the competing pressures the PCTs and Practices found themselves operating in:

"The Chief Exec that backed it has gone, the Chief Exec that backed it after that has gone, the Chief Exec after that's gone! Out of ten directors we've got two left, it's the reality. We've got a financial deficit that we had to turn round so that's the context of all this it's not easy so I think the work itself has been excellent." PCT-based stakeholder, Bradford

3.1.4.4   Financial issues

- Competing pressures were seen to exist for GPs, including meeting their QOF[1] targets:

"They are very focused on and distracted by the QOF. There was some talk about until you start getting points for self care (reduction in waiting lists etc) and they get some kind of payback that will make a real difference. If it's the time of the year when they look at QOF points then everything else is put to one side." PCT-based stakeholder, Lambeth & Southwark

- Although all Practices were offered back-fill to attend the training, there was an impression given that the Practices did not feel adequate moneys had been put aside to back-fill posts for staff time whilst they were on the training programme.[2] GPs also felt that they should be given an incentive to undertake this new role:

"Also, GPs seem to expect payment or incentives. I don't see why we have to give them incentives but we do. It seems to be the culture." PCT-based stakeholder, Lambeth & Southwark

- The general feeling in some PCTs was that financial constraints prevented them from rolling the programme out across many Practices:

"We should have put £200,000 in to this. We put nothing in, we should have had two managers, we didn't have them. We've scraped together and made it work through determination. PCT-based stakeholder, Bradford

3.1.4.5   Marketing

- It was suggested that there should be careful marketing with the Practices over what the package had to offer. Information on benefits, in the form of money or time saved, needed to be provided to create a business case for the Practice based Commissioning consortia.

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[1] The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results and was introduced as part of the GP contract in 2004.

[2] Only a small number of Practices took up the offer of backfill from the PCT.

- There was scepticism due to the lack of research on the effectiveness of the initiative, although it was understood by some interviewees that one of the aims of the project was to provide research evidence:

"The partners need to be more confident that it can make a difference to workload – if we could demonstrate that then it could start to gain some momentum... Probably because they have tried things in the past which haven't worked – the doctors have seen that patients have gone down a different route but still ended up coming back to them." PCT-based stakeholder, Cheshire

3.1.5 Recommendations from the stakeholders

- Changes were felt to be needed both with the public and at all levels of the health service for the initiative to work. This needed to be in synchrony to ensure both the public and professionals understood what was going on and how they fitted into the changing culture:

"A clinician cannot help you lose weight, they can advise you, help you, support you, keep your morale up but they can't do it for you. This project legitimises that from the organisation. …It's trying to get people not to see it as a separate project but it's about getting it embedded in their thoughts and when somebody sees a clinician they're not just saying 'oh well do this, do that or take this medicine', it is about saying 'let's have a look at you as a whole, what you can do to help'." PCT-based stakeholder, Cheshire

- There was recognition that the current health system could not survive due to the resources it demanded and that there had to be a change in people's ability and skills to take care of their own health needs and to be better able to avoid ill-health.

- The extent of the philosophy behind self care had yet to be realised by many and the stakeholders tended to feel that it was too early to see changes, but that the seeds had been sown;

"If we don't do it the costs will be horrendous and we'll have loads of ill people. It's worth investing the money to promote this self care and legitimise it and empower people to promote it and use it because that will be cheaper than the consequences if we don't do it. It's long term and you won't see an immediate saving, you're probably talking 5-10 years before you'll see it." PCT-based stakeholder, Cheshire

- Although the initiative is aimed at producing culture change across the whole system, there was an expectation that it would be the nurses who eventually develop this initiative:

"Making sure the PCTs have the strategy in place, marketing to the acute trusts, and looking at the nursing workforce, rather than GPs. The GPs want to do their clinical intervention, make a drug prescription, the nursing staff [have] the more holistic proactive conversations with patients." PCT-based stakeholder, Lambeth & Southwark

- The stakeholders also recognised that quite fundamental changes to how Practices are organised and run were required. For instance, structural issues of providing an integrated self care support resource or facility were raised:

"If we're thinking about the Practice buildings and how we develop the Practice facility, what do we need to be thinking about in relation to self care. We need to provide an area where we can give them access to tools were they can learn how to care for themselves, access different services, people that are coming in and have supporting services that can help patients to self care. We need to make sure that we can provide that facility within the Practice." Practice-based stakeholder Bradford

3.2 Professionals' perspectives

Evaluation and monitoring forms collected from the training workshops in Lambeth and Southwark and Central Cheshire PCTs indicate that all professional and Practice staff roles were represented but that there was diminishing attendance over time and in some cases workshop 3 did not take place (Table 3.2). We do not know what proportion of professionals and Practice staff from participating Practices did not attend the workshops.

Table 3.2   Professional and Practice staff roles attending workshops

Role	Workshop 1	Workshop 2	Workshop 3
GP	10	6	2
Nurse	5	2	1
Pharmacist	4	2	0
Receptionist	12	12	5
Practice Manager	4	3	1
Administrative support staff	6	6	3
Health Care assistant	2	2	0
Mental health worker	1	0	0

3.2.1 Beliefs and attitudes about self care

Findings from Baseline questionnaire

Forty-two Primary Health Care Professionals and Practice staff returned the baseline questionnaire. 28 (67%) of respondents stated that they were in regular contact with patients.

Table 3.3   Professional and Practice staff respondents to baseline questionnaire

Role	
GPs	8
Practice Nurses	5
Pharmacists	5
Practice Managers	6
Health Care Managers	2
Other (Project Manager, Public Health Manager, Health Care Assistant/Support Worker, Mental Health Worker, Office Manager, Reception/ administration/ secretary/ PA, IT administrator)	16

- At least 50% of respondents felt that they had the knowledge, skills and training to enable patients to self care, although more than one fifth of respondents were uncertain.

- The majority of participants, 74% (n=31) did not think that they had done any previous training in relation to enabling and supporting patients to self care.

- Overall a high percentage (67%, n=28) reported that they had spoken to patients about self care in the last six months, even if only occasionally.

Table 3.4   Examples of self care activities respondents had talked to patients about

Signposting patients on:	Expert Patients Programme; Breathe Easy; Lifestyle advice; quit smoking; self help information on the internet; encouraging patients to follow up results and appointments

Managing medicine:	Medicines to treat disease; non therapeutic options in taking care of illness or health conditions; optimising the use of medicines; managing medicines (e.g. inhalers)
Lifestyle:	Encouraging healthy diet and exercise; encouraging less alcohol intake; smoking cessation; washing and cooking; self care for anxiety and depression; prevention rather than cure (e.g. athletes foot)
Taking care of minor ailments:	Monitoring diabetes; taking care of back pain, coughs, colds and sore throats; coping with pain, grief, loss

- Participants were asked to rate the importance of a list of factors in influencing how much a person is motivated to self care. 61% of respondents rated "education" as important, followed by age (24%) and time (9%).

Findings from exit questionnaire

- A total of 26 primary health care professionals completed the exit questionnaire. These were not the same respondents as for the baseline questionnaire. A large proportion of respondents (92%, n=24) stated that they were in regular contact with patients.

Table 3.5   Professional and Practice staff respondents to exit questionnaire

Role	
GPs	10
Practice Nurses	3
Health Care Assistant	3
Practice Managers	2
Administrator	2
Receptionist	2
Other (dietician, health visitor, medical secretary, primary care mental health worker)	4
Total	**26**

- More than half the respondents reported that they had the knowledge, skills and training to enable and support patients to self care; around a fifth were uncertain and a further fifth disagreed.

- The majority of respondents (> 70%) agreed that self care improved people's self esteem, was likely to be of benefit to most patients, and was a good way to make patients invest in their future.

- More than half of respondents agreed that self care works if patients know when it is relevant or not and that training patients is of value.

- Only 40% of respondents thought that self care was likely to work only on the most motivated patients.

- More than half of respondents stated that they often or very often spoke to patients about self care. Examples of self care activities spoken about included: self care of minor illnesses, care of long term conditions, diets and exercise, signposting and smoking cessation.

- Participant responses were not related to their professional role.

- Participants believed that the most important factor to influence patients' motivation to self care was "education", with time, age of patient and financial status also having influence.

More details from PHCPs questionnaire data can be found in Appendix 6.

Findings from qualitative interviews

A total of 21 interviews were conducted with health care professionals and staff from intervention Practices in each of the three PCT areas. Interviewees had a wide range of roles, skills and responsibilities.

Table 3.6   Professional and Practice staff interviewees

PCT Area	
Bradford	10
Cheshire	7
Lambeth and Southwark	4

Interviewees reported performing the following roles: Data Quality Technician; General Practitioner; IT Developer; Patient Services Manager; Personal Assistant; Pharmacy Branch Manager; Practice Manager; Registrar; Accounts Manager; Health Care Assistant; Office Manager; Practice Nurse; Receptionist; Senior Receptionist; Support Secretary; Primary Care Mental Health Worker.

- Primary Health Care Professionals' perceptions of the concept of self care were generally positive, with many staff seeing self care as a patient responsibility. It was felt that self care would build confidence in patients and empower them to take care of their health more independently.

- Interviewees felt that the use of self care would enable resources to be utilised in areas of greater need:

"It will save GP appointments for more ill patients and in the long run it will help people look after themselves." Accounts Manager

- Confidence in talking to patients about self care varied across role. Receptionists were in general cautious about providing self care advice, emphasising the need for backup from the team and further training. GPs and other practitioners were however more confident, with some seeing supporting self care as part of their role.

3.2.2 Starting point

Findings from qualitative interviews

- The majority of interviewees felt that their Practice was already active in supporting self care. A variety of self care support practices were reported, including routine promotion of self care within the Practice, and self care within consultations.

- Signposting was also seen as a key aspect of supporting self care within Practices, with receptionists being seen as well positioned to utilise their skills and patient knowledge in signposting patients to relevant self care information resources such as the pharmacist or NHS Direct.

- Other systems of supporting and promoting Self Care included the Expert Patients Programme, minor ailments schemes, healthy living groups and networks and regular health promotion forums involving Practice staff. One participant also highlighted the development of a register for patients with diabetes which would enable Practice staff not only to arrange appointments more efficiently, but also to form self care support networks; however this (the register) is already a requirement of all Practices under QOF.

- Triage systems involving receptionists and nursing staff within the Practice and engagement with community partners such as local pharmacies were also in place in some Practices.

- The use of protocols such as those to be used in the screening of patients presenting with sore throats was seen as beneficial. Despite the use of protocols having been discussed in a number of workshops, it was reported by a number of professionals that these procedures had not been commonly implemented.

3.2.3 Views on SCinPC

3.2.3.1   The training workshops

Findings from qualitative interviews

- Participation in the self care workshops was not universal, with three of the 16 members of staff stating that they had not attended the meetings, others were unsure or had only attended one session.

- It was suggested that members of staff who did not attend the workshops were not made aware of the issues raised within the groups. Of those professionals who did attend workshops, a large proportion stated that they had no expectations about the content. The role of the interviewee appeared to play a part in determining expectations and understanding of the workshop, with senior staff members reporting a greater understanding than more junior roles.

- A large degree of variation in the content of the self care workshops was noted. Issues covered in the workshop were reported to be formation of teams, minor ailments, screening and triage, raising awareness of self care and providing advice. Interviewees did not recall working with any specific tools, but in three Practices interviewees mentioned that they had been put into groups to discuss self care needs and solutions in the Practice.

- Benefits of the workshop were perceived to be focused around issues such as raised awareness of existing and alternative services, reinforcement of self care values and increasing commitment to self care and signposting to self care support facilities. Secondary effects of the workshops included mobilisation of the team to support self care and the value of this mobilisation to the Practice more generally:

"It was really good to have that conversation amongst the team in general because I don't think it's a doctors or nurses job only." General Practitioner

"One thing I'd like to say about gains from the self care workshop is it has given me opportunity to get involved with the Practice." Pharmacy Branch Manager

- Respondents were critical of the lack of organisation and focus of the workshops and some interviewees felt that they had not gained anything from the workshops. It was suggested that the workshops sometimes lacked organisation and clarity. The benefit of external facilitation was stated, as it was felt that this would improve engagement:

"I felt the meeting was disorganised, that there hadn't been a strategy developed and everybody was going straight into solutions." Pharmacy Branch Manager

"It made us realise that sometimes we can't do all this ourselves, sometimes you do need somebody from outside to come in because if I stand up at the front there, most people won't be as open because they think well [name] might think I should know that or something, so they're not as open. So I think sometimes although it may cost you, it's beneficial to say to somebody can you come in and just facilitate that for us." Patient Services Manager

- Whilst only highlighted by one participant, there was also criticism concerning the demarcation of mental and physical health care within the workshops. It was suggested that self care support for mental health was largely excluded from the workshops, therefore impacting on staff members working within the field of mental health.

3.2.3.2   Developing SCinPC in Practices

<u>Findings from qualitative interviews</u>

- Interviewees emphasised that implementation of change within Practices and within the NHS as a whole was a slow process, with some professionals questioning the capacity of their Practice to implement change and the overall commitment to supporting self care. These were commonly cited as barriers to progress:

"I think we're still trying but I think it's slow progress." Personal Assistant

- There was a perception from some staff members that supporting self care was not considered to be part of their role, or their role did not enable them to support and promote self care within the Practice. It was therefore suggested by some that responsibility must lie with the GP. This could also be related to lack of training among staff leading to lack of confidence in supporting self care:

"It's not my role to advise patients... We're told how to deal with queries and we do on the phone have to give out certain amounts of advice but very generalised and usually with the backup of the doctor." Personal Assistant

- There was a concern over the accountability of receptionists required to screen patients with minor ailments. It was reported that receptionists were often nervous of incorrectly screening patients and missing more serious conditions.

- Respondents cited inconsistent or incorrect advice as possible areas of concern. It was also felt that a policy to encourage self care may send out the message that patients should avoid or delay seeking help, potentially having serious effects on patients' health:

"We could give someone wrong advice and you don't know what might happen." Receptionist

- Whilst respondents did highlight the financial costs associated with the care of minor ailments within Practices and the potential savings of supporting self care, some participants expressed doubt over its cost effectiveness within the Practice. It was suggested that dissemination of a self care culture through the family could be a more effective method of promotion.

3.2.3.3 Impact of SCinPC

Findings from baseline questionnaire

- Participants were asked *'What do you think are the three most positive potential outcomes for the Self Care in Primary Care initiative?'* Their responses are illustrated below:

Table 3.7 PHCPs' and Practice staff responses to 'most positive potential outcomes' for SCinPC initiative

Improved patient health	Involvement of patients in their own care; raised awareness; better skills for patients; knowledge and expertise to self care; long term health gain; patients realising that providing support for self care is a positive and valid intervention; access to information resources
Improved patient self esteem	Promotes patient empowerment; improved quality of life; increased confidence in taking care of own health; happier patients who are able to depend on themselves more
Improved health services	Cost effective use of services; less prescriptions issued; minimising GP consultations and admissions to hospital; less unnecessary consultations; more efficient and appropriate use of PHCPs; time saving in Practices; increased appointments for truly needy

	patients; better partnership between patients and professionals; ability to direct patients to other places of care; increased patient satisfaction
Guide for future of SCinPC	To assess training needs for professionals to acquire the skills to support and encourage self care; to support professionals in teaching the benefits of self care

Findings from exit questionnaire

- Not all respondents had knowledge of the Self Care in Primary Care initiative. While 56% (n=14) of those answering the question stated that they had heard of the initiative, 40% (n=10) had not and one person was unsure.

- Attendance at SCinPC workshops was not universal. Of those who answered the question, only 36% (n=9) stated that they had attended a workshop, with the remaining 64% (n=16) reporting that they had not attended any workshops.

- Only two of the 26 respondents stated that they had used any of the tools linked to the workshops ('Access to patient information sheets' n=1; no detail provided n=1), while a further five were unsure whether they had used any of the tools.

- Despite poor attendance rates at workshops, 42% of respondents (n=11) stated that they had personally been involved in making plans or changes around supporting self care in the Practice, 50% (n=13) stated that they had not been involved and 8% (n=2) were unsure. Furthermore, 46% (n=11) of those answering the question were aware of activities taking place at the Practice as a result of the SCinPC initiative. Reported activities already in place included information available in the waiting area (42%, n=11), receptionists using a triage system for appointments (19%, n=5), extra self care skills training for staff (27%, n=7), setting up patient groups (35%, n=9) and improved links with pharmacy (31%, n=8).

- Staff members' perception was that the impact of the SCinPC initiative was low. Of those answering the question "What impact do you think the Self Care in Primary Care initiative has had on what happens in your Practice?", 59% (n=13) of participants stated that the initiative had either a limited or very limited impact on what happens within the Practice. 41% (n=9) believed that the initiative had some impact. In explanation of these answers, participants reported such issues as staff shortages and time constraints as reasons for the low impact.

Findings from qualitative interviews

- There was considerable variation in how the intervention was implemented in each Practice (see Table 3.8). Three Practices implemented a receptionist triage system, one focused on audit of minor ailment consultations and one focused on patient information. Two Practices did not implement any significant changes as a result of the initiative. Minor ailment schemes were mentioned by interviewees in several Practices but these seemed to be taking place already and were unconnected to the SCinPC initiative,

Table 3.8 Implementation of SCinPC in Practices

Practice	Changes implemented as a result of ScinPC
Ilkley Moor	Audit of minor ailment consultations. Intention to work more closely with pharmacist.

Princess Street	Increased patient information: notice board and leaflets – increased signposting (via written material) to NHS Direct and pharmacist
Streatham Place	No change implemented
Tudor	Receptionist triage – without protocol. Nurse triage (unclear whether due to SCinPC)
Vauxhall	No change implemented.
Weaver Vale	Receptionist triage – with protocol. Increased use of minor ailment scheme?
Wilsden	Receptionist triage. Working more closely with pharmacist. Increased access.

- There was indication from some Practice staff that aspects of self care had been implemented within Practices. Interviewees talked about directing patients to the triage nurse or minor ailments scheme, signposting, improved communication amongst staff and delivering more self care advice. It was not, however, clear whether these changes were implemented as a result of the workshops.

- Some professionals and Practice staff were critical of the failure to follow up planned action within the workshops. Although issues such as signposting and the establishment of screening protocols were discussed within workshops, a number of professionals stated that these were not implemented. For example, it was stated by one professional that an action plan was drawn up, but this ultimately 'fizzled out':

"I've been wondering what's been going on with this initiative and how we've been getting on in the Practice because it's kind of disappeared and died a death from my view point." Primary Care Mental Health Worker

"I think if we knew that people were going to be coming back to us and saying, 'How's it going?' or whatever I think that would make it much more likely that things would happen." General Practitioner

- Professionals' perceptions of the impact of SCinPC on patients were inconsistent. There was an acknowledgement from some professionals that SCinPC was unsuccessful or indeed irrelevant with a suggestion that staff had not changed their practice. In contrast some Practice staff suggested that SCinPC assisted Practices to change patient attitudes to self care, nevertheless it was perceived that any change would be a slow process:

"They seem to have got their head round it but you obviously get the ones who have always been to the doctor and it's hard to break [to them] that self care can help them but we're getting there. We're chipping away and we are getting there with them." Health Care Assistant

- Change in some patients' health behaviours was also reported, for example the willingness to change dressings, consulting information resources and monitoring for signs of infection. However once again staff emphasised that attitudinal change within patients was a slow process.

- A number of barriers to the implementation and success of SCinPC were highlighted. Health care staff stated that there was a lack of time and resources to implement any further self care support activities within Practices:

"We don't have a huge amount of capacity to be doing new pieces of work at the moment." General Practitioner

- Reference was made to other responsibilities of health care staff, which may conflict with supporting self care. Receptionists in particular were highlighted as

staff members who were put under particular pressure with the demands from their role in triage. It was also suggested that there was no incentive for receptionists to promote self care:

"The girls [on reception] think why should they do it when they're not paid a major amount of money." Office Manager

- Resistance to self care from health care professionals was cited as a key barrier to change. Several respondents felt that supporting self care was not a priority within the Practice. Others talked of a lack of training, or did not feel that it fell within their role:

"I can't say it's something I relish doing because I've not had proper training. We've had the basic training but nothing major." Office Manager

- Patients were also seen as resistant to change. One professional stated that it was important to catch people early, emphasising that it is harder to change the behaviour of older people. It was stated that some elderly patients felt that it is their 'right' to see the doctor:

"The patients get used to having things automatically done I think and I think it's hard for them to be educated into looking after themselves more." Personal Assistant

"I think it takes forever! Any changes, you might get some very quick wins for example signposting that might be some quick links to divert people to information that can help them. But I think to change behaviour we all know it can take a very long time and it depends on the individual." General Practitioner

- There was a suggestion that 'the system' was not accommodating of self care, and was potentially providing perverse incentives. Examples such as easy access to GPs, walk in centres, described as pampering to the 'worried well', and exemptions from prescription charges were seen as encouraging some patients to attend the Practice rather than self caring.

3.2.4 Recommendations from professionals and practice staff

- Respondents felt that the training workshops should have more structure and purpose, with one person 'owning' and taking responsibility for the initiative, ensuring that outputs are implemented.

- A strong theme within the interviews was a call for further training of all Practice staff, from receptionists through to GPs.

- A team approach was seen as valuable for the development of policies to support self care within the Practice.

- Consultation with patients was seen by some staff as a valuable exercise in the development of self care support policies within Practices. It was suggested that the GP had a responsibility to emphasise to patients that they do not have to see their GP every time they require assistance.

- Professionals emphasised the importance of standardised, national guidelines and the use of clear protocols so health care professionals and reception staff can deliver a clear and consistent message to patients:

"It would help if we could have some guidelines once and for all which would clear up these mysteries which probably is a high expectation. You work one way for 3 years and then they get this paper out which completely undoes the whole system. And everyone

goes I told you so, so people are reluctant to be forceful if they think in 3 years time somebody will come and turn the advice over." General Practitioner

- The use of promotional materials, particularly leaflets, were also seen as beneficial:

"What I'd like to do is find out from everyone else because we haven't really got together as a team as it were, and to find out what everyone feels is important and then work out how as aPpractice we could take that forward." Practice Nurse

- Respondents also stated the need for developments to be made in wider society. Some respondents saw education of patients from an early age as a vital exercise for further implementation of policies to support self care. One respondent also felt that the media could play a role in encouraging change.

4. Patient perspectives

Summary of key findings

- ▪ Health literacy improved in both intervention and comparison groups over the twelve month follow-up period
- ▪ Patients' knowledge about minor ailments did not show consistent change over the 12 month follow-up period
- ▪ Patients were confident in their ability to self care, although there was wide variation in definitions and understanding of the concept of self care and what it involves
- ▪ Patients in the intervention group were less keen than those in the comparison group on future use of advice and information services such as NHS Direct
- ▪ Choice of support was strongly related to the perceived level of seriousness or level of concern attached to ailments
- ▪ Patients were concerned about continuity of care and accessibility of primary care services

4.1 Characteristics of frequent attenders

1454 participants took part in the study: 746 from intervention practices and 708 from comparison group practices. 66% were female and 94.8% were White. 3.9% reported their ethnicity as Black, 0.7% as Mixed and 0.6% as Asian. 27% reported that they had no qualifications, while 18.5% had qualifications to degree level or equivalent. A higher proportion of people in the comparison group than the intervention group reported having no qualifications (36% vs 24%), and a higher proportion of people in the intervention group than the comparison group reported having a degree or equivalent (26% vs 15%). 73% lived with family, while 23% lived alone. 84.4% considered themselves to have health conditions (83.4% in the comparison group and 85.4% in the intervention group) – this is high compared with 2001 Census results (18.2% in England and Wales reported limiting long term illness while 9.2% said their general health was 'not good'). No significant differences were found between intervention and comparison groups for any demographic characteristics at baseline.

Table 4.1   Participant (patient) demographics

Category of participants	Intervention n (%)	Comparison n (%)	Total N (%)	Census 2001 (England and Wales)
Total	746	708	1454	
Male	266 (36%)	225 (32%)	491 (34%)	49%
Female	472 (62%)	474 (68%)	946 (66%)	51%
White	688 (92%)	672 (95%)	1360 (95%)	91%*
Black	29 (3.9%)	25 (3.5%)	54 (3.7%)	2.3%*
Asian	8 (1.1%)	1 (0.1%)	9 (0.6%)	4.6%*
No qualifications	221 (24%)	166 (36%)	387 (27%)	29%
Degree or equivalent	177 (26%)	92 (15%)	269 (18.5%)	20%
Live with family	537 (72%)	521 (74%)	1058 (73%)	n/a
Live alone	183 (25%)	153 (22%)	336 (23%)	30%
Health conditions	626 (85.4%)	579 (83.4%)	1205 (84.4%)	18.2%

*England only
More details of participant demographics can be found in Appendix 7.

Figure 4.1 depicts the three categories of self care that were examined through the patient questionnaires and interviews.

Fig 4.1 Diagram showing the different components of Self Care
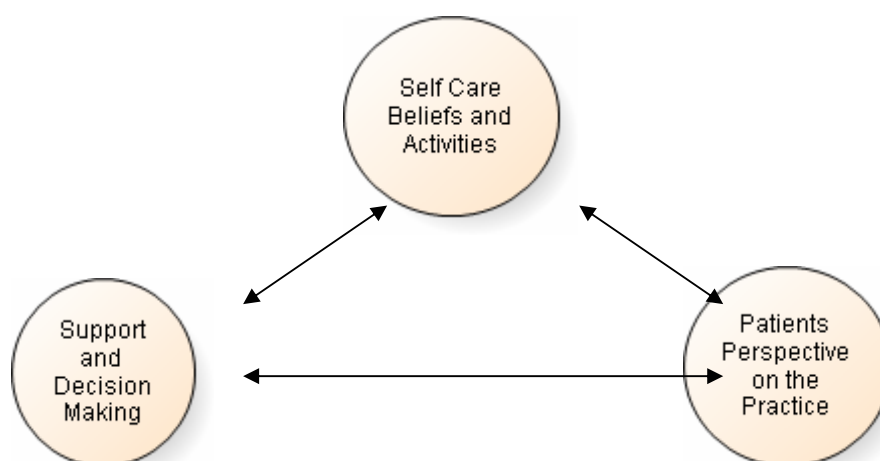
4.2   Self care beliefs and activities

4.2.1 Findings from patient questionnaires

4.2.1.1   Knowledge of specific minor ailments

At **baseline**, the majority of people reported that they knew 'a little' or 'a reasonable amount' about back pain. When asked about asthma, the majority of people said they knew 'a little' or 'nothing at all'. For adult cough and sore throat, there was a significant difference (chi-square p<0.001) between intervention and comparison groups, with a higher proportion in the comparison group reporting that they knew 'nothing at all' or 'a little' and a higher proportion in the intervention group reporting that they knew 'a reasonable amount' or 'quite a lot'.

At **six months**, the findings were very similar to baseline, except that knowledge about sore throat and adult cough seemed to have increased in the comparison group, such that there was no longer a statistically significant difference between groups. At **twelve months**, knowledge about back pain had diverged between the groups: more people in the intervention group said they knew 'nothing at all' or 'quite a lot' and more people in the comparison group said they knew 'a great deal' or 'a little' (chi-square p=0.036). There was no statistically significant difference between groups in knowledge about asthma, adult cough or sore throat.

4.2.1.2   Health literacy

Patients were asked to rate their agreement with three statements relating to health literacy, under the heading 'Caring for Yourself' (see Appendix 3 for more details). At **baseline**, the mean score in both groups was 9.7 out of a possible maximum score of 15. At **six and twelve months**, the scores in both groups had increased. There was a statistically significant difference between groups, in favour of the intervention group, (see Table 2) of 0.35 points on a 15 point scale.

4.2.2 Findings from qualitative interviews

4.2.2.1 Understanding of the concept of Self Care

At baseline all patients were read the following definition of self care;

Self Care is the care taken by individuals towards their own health and well being, It includes the actions people take to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions and maintain health and wellbeing after an acute illness or discharge from hospital.

- Patients expressed a diverse range of personal definitions of the term 'self care' during follow-up interviews. A common theme amongst men and women was that self care referred to 'looking after yourself' and independent care. Other patients used the term in relation to more defined issues such as; maintenance of a healthy lifestyle, preventing illness and care of minor and long term illness:

"Look after yourself, keep yourself warm if you need to, don't do anything that's going to damage your health like over drinking at the pub or whatever if that's what you do or as some people with smoking which I never do, you could be doing too much of that. That sort of thing." Male aged 71[3], Bradford

"Well I guess kind of looking after yourself and doing, doing what you can to prevent any illness or injury and then maybe kind of looking after yourself maybe when you do get an illness, rather than relying on, rather than relying on a GP." Male aged 16, Bradford

- At twelve month follow-up, patients were encouraged to state how they had come about their definition of self care. The strongest theme which emerged was that the definition had just come about through personal experience, something which had been formed 'over the years', or simply common sense. A small number of participants stated that their understanding of the term was partly influenced by taking part in the study.

- A small number of patients were uncertain about how to define the term. Whilst other patients were more explicit in stating that they had little or no understanding of the term.

4.2.2.2 Confidence in the ability to self care

The vast majority of participants stated that they were either 'fairly confident' or 'very confident' in their ability to self care.

- *"All the way, 100% me."* Male aged 68, Cheshire

- The small number of participants who were less confident in their ability to self care highlighted a lack of additional support as a barrier to self care:

"I haven't got a lot of confidence, I like to know that there is someone there I can speak to, you know if I've got problems like." Female aged 53, Cheshire

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[3] Ages given in the text are participants' ages at the time of filling in the baseline questionnaire.

- Others emphasised that their confidence in their ability to self care was affected by other factors such as mental health:

"I would say in times of, when something becomes severe depression I don't think at that stage I'm able to manage my health as well because I'm just not able to cope."
Female aged 52, Bradford

4.2.2.3   Self care activities

- The two most commonly cited self care activities were regulation of diet and exercise (*e.g.* walking, going to the gym, eating 5 fruit and vegetables a day, and monitoring calorie intake). Several participants stated that their current health condition did not permit them to participate in exercise:

"I have a job to even hoover up, but I do try and walk a little bit, I just try to walk to the end of the road and then I'm out of breath." Female aged 63, Cheshire

- A number of participants saw care of minor ailments, and in some cases long term conditions as an important aspect of their self care regimen. Several different methods of self care were reported, including self medication using over the counter medicines and pain management:

"I always do what my grandma used to say – break 2 Paracetamols up with 2 spoons together in warm lemonade and drink it … just get wrapped up and sweat it out." Male aged 44, Bradford

- A number of participants reported that they would monitor their condition, either leaving it to run its course, or performing ongoing assessment of the condition, only visiting the doctor if the condition persists, whilst others said they would not do anything:

"Generally if I've got aches and pains I'll think ay up, what's that, think about it, what's that, it'll pass or whatever and if it's something I need to do or contact somebody about or do some self help, that's what I do." Male aged 59, Bradford

- Other themes that emerged related to patients' abstention from, monitoring or limiting smoking and drinking, participation in activities, which they found to be relaxing and keeping mentally and physically active.

4.3   Support and decision making

4.3.1 Findings from patient questionnaire

Participants were asked about their intended future conduct with regard to visiting the GP with a minor ailment, and making use of advice and information services such as NHS Direct. At **baseline**, the majority of people stated that they agreed with the statements "I intend to visit the GP/ family doctor less if I have a minor ailment" and "I intend making use of advice and information service". There was however a statistically significant difference (chi-square p<0.001) between the comparison and intervention groups in response to the latter statement, with a higher proportion in the comparison group agreeing and a higher proportion in the intervention group disagreeing with the statement. At **six months**, the difference between groups was more pronounced with participants in the comparison group more likely to agree with either statement than participants in the intervention group (chi-square p=0.001 in both cases). At **twelve months**, there was no statistically significant difference between groups in response to the minor ailment statement but the difference between comparison and intervention

groups for the statement about using advice and information persisted (chi-square p=0.006)

4.3.2 Findings from patient qualitative interviews

4.3.2.1   Decision making
At both baseline and twelve month follow-up participants were encouraged to describe how they decide what to do if they have a health problem.

- Choice of support was strongly related to the perceived level of seriousness or level of concern attached to the ailment, with patients stating that they would not go to the GP if it was a minor ailment:

"If I thought it was something serious or something I couldn't sort out me-self I'd have no alternative but go to the doctor and I've got an absolutely first rate doctor." Female aged 74, Cheshire

4.3.2.2   Sources of support
- A large proportion of participants at baseline stated that they would turn to their GP should they have a health problem, some of whom stated that they would turn to their GP as the first point of call.

- At twelve month follow-up interviews the use of GPs as a source of support continued to be a strong theme within interviews, with some participants still seeing the GP as the most appropriate first point of call:

"My GP would be the first port of call if I felt there was something that warranted proper medical intervention. I would only use these other things if I felt it was something fairly minor that I could manage myself, you know with a bit of advice." Female aged 58, Cheshire

- Although not as strong a theme, patients also reported using other Practice staff as source of support, for example the triage nurse, a Practice nurse or specialist at the Practice:

"I would prefer to see the nurse practitioner now just because I feel that I'm not disturbing the doctor." Female aged 37, Cheshire

- A few participants did however express a clear preference for gaining the advice and support of GPs over other members of Practice staff.

- Although not a common theme in the interviews, a comment was made at twelve months follow-up concerning the rights of patients to use health services:

"I pay an awful lot of tax, to the government and I'm told that I have a national health service therefore my view is that I should use it." Female aged 41, Lambeth and Southwark

- A strong theme within the interviews at baseline and twelve month follow-up was use of the pharmacist as a source of support. For some participants attending the pharmacist to get advice and support with minor ailments was a precursor or supplementary to attending the Practice:

"I'm quite happy to see the pharmacist and he'll tell me whether I need to see the doctor, anyway most of the time I don't." Male Aged 63, Cheshire

- A small number of participants commented on going to the pharmacist as a means of saving their own, or their doctor's time:

"Our pharmacist is able to do prescriptions himself, so I think that's to take pressure of the doctors a bit." Female aged 33, Cheshire

- A small proportion of participants had either not considered the pharmacist as a source of support or felt it to be inappropriate as a source of support:

"I don't know, I still think generally think of them as the people who hand out what the doctor tells them to... I don't personally perceive them as the experts in, in my condition." Male aged 52, Bradford

- Another heavily cited source of support at both baseline and twelve month follow-up was the family and friends:

"If they think you are neglecting yourself, they do push you into action, I certainly think family are important, and sometimes second hand experiences from friends point you in the right direction I think." Female aged 73, Bradford

- For others family and friends were not sufficiently equipped to deal with health related issues, and a number of participants felt that family members would worry unnecessarily should they turn to them for support:

"I don't very often talk to family mostly because they live a long way a way and if I'm a bit concerned about something they might worry unnecessarily." Female aged 69, Bradford

- Participants were asked about alternative sources of advice and reported use of NHS Direct and telephone consultations use at both baseline and twelve months. Patient satisfaction of NHS Direct services varied. Some participants provided positive examples of using the NHS Direct phone line and website, highlighting the value of the service in terms of support, out of hours care and as an alternative to attending the GP:

"She had a temperature and she was vomiting and it was a weekend I phoned, they said keep her hydrated. Mostly it was just common sense but I needed the back up for someone else to tell me that." Female aged 57, Cheshire

"Being a man and not being one to admit it...I might be working away or going to the doctors impinges on my work schedule...I'll probably ring up NHS Direct." Male aged 52, Bradford

- There were, however, some participants who expressed negative opinions about the service. Patients were critical of the service's inability offer firm advice, the lack of patient knowledge and the inability of NHS direct phone line operators to offer a diagnosis. Some participants stated that they had had bad experiences of using NHS Direct:

"First thing is, when you're speaking to somebody over the phone they can't see you, therefore they cannot make a... proper diagnosis of what you're talking about, because when I say something, I could be saying what I believe not what is correct... there is absolutely no way that I would use NHS Direct for absolutely anything what so ever, if I have a problem major or minor, I go to my GP." Male aged 71, Bradford

- Other support services reported to be used by participants at baseline and twelve month follow-up included the internet, the public library, alternative therapists (acupuncturist, herbalist etc):

"I use the internet a lot actually... I usually just type in the problem or whatever it is I want to know about and then just go on to whatever websites come up really." Female

aged 33, Cheshire

4.4 Patients' perspectives on the general practice.

- At six months and twelve months follow-up the majority of patients had been to the Practice to see their GP. A large proportion of patients had seen a Practice nurse, or a nurse specialist, commonly for routine checks. Only a small number of patients had had contact with the Practice using a telephone consultation.

4.4.1 Patient satisfaction

- Overwhelmingly patients provided positive feedback about the service at their Practice. Critical themes emerged relating to continuity of care, with a number of respondents commenting on inconsistent patient care. Some patients were also critical of their Practice not providing out of hours care, with concern expressed about being ill out of practice hours and accessibility of care.

4.4.2 The appointment process

- At twelve month follow-up, some participants described the screening or triage process at initial contact with the Practice. This involved being asked 'what's wrong?' by a receptionist, or referred to a triage nurse who would then triage the patient. However not all patients reported any triage being in place. It was not clear whether participants' perceptions of these procedures in Practices reflected actual process.

- Whilst some patients stated that they were always able to see the health care professional they requested, others reported that who they were able to see was dependent upon how busy the practice was and how urgent the perceived their condition to be:

"I see whoever's appropriate, I mean if I need to see a GP then I'll get to see one. One has to wait till one's turn, but I mean, I think if I was to go and say, you know, I have desperate need I think I would get immediate care, but in general circumstance, I wait like everybody else." Male aged 63, Cheshire

- A strong theme among patient responses was that in order to get a same day appointment, there was a requirement to ring before a designated time, a number of patients expressed dissatisfaction with this procedure:

"Other than that, when it comes to the doctor that's the big bugbear... I couldn't phone up now and say I'd like an appointment tomorrow. You've got to phone between 8am and 9am... and on a Monday morning, forget it, because you've got so many guys don't want to go into work." Male aged 68, Cheshire

Some patients stated that they were not always able to see their preferred GP when they attended the Practice. Response to this lack of choice varied:

- *"No, you just get whoever, whoever is available… It's fine, I don't like one of the GPs so I always ask not to see him, but the other ones are okay, think I've seen a locum as well and generally it's fine."* Female aged 28, Cheshire

"They always say to me, you can see somebody today but it won't be your own GP, so I usually wait... unless it's, you know, desperate." Female aged 64, Bradford

4.4.3 Consultation

- The strongest theme amongst patients asked about their preparation for a consultation was that they did not prepare for a consultation in any way. Some

patients stated that their consultation process was on-going and therefore did not require any preparation. Other reasons for not preparing included lack of time and a belief that it wasn't a patients 'duty' to prepare.

- Of those patients who did prepare for a consultation the most commonly reported activity was taking notes into the consultation. Some patients also talked about making mental notes on items which they felt required discussion with the doctor:

"I had to when I had my six week check, after having my daughter obviously because you forget a lot of things... It did come in handy because I didn't forget anything, but I don't usually go with a list of ailments." Female aged 21, Cheshire

- Some patients talked about undertaking research into their condition prior to seeing the doctor, this involved consulting with internet sources, or medical text books. Others talked about monitoring their condition, performing such activities as taking their blood pressure.

- Participants were asked to describe what happened in a consultation with their GP. The majority of respondents indicated that they were active within a consultation, discussing their condition with the GP and questioning the GP's advice. A theme among respondents was the patient perception that the GP was too busy, that there was a lack of time for discussion:

"It's always a two-way traffic, I mean firstly the doctor says, what can I do for you... but you know they don't have very much time to give to each patient and I understand that... I tend not to waste any time." Female aged 68, Bradford

4.4.4 Doctor-patient relationship

- The majority of patients talked about having a positive doctor-patient relationship with a good level of trust:

"Very, very good, I can talk to them, discuss anything with them, and they're always listen and they're always helpful, sometimes in the past they haven't given me the answer I'd like, but they're, at least they're truthful." Male aged 68, Cheshire

- Many patients appeared to value the continuity of care, which was achieved by having a long standing general practitioner:

"I actually think that that's really important... over the time you build up a trusting relationship with your GP which I don't think I would feel if I saw a different person each time I went." Female aged 58, Cheshire

- Among those patients who reported a negative relationship with their GP, a lack of continuity of care was seen as a factor:

"No, but you don't get to know them as well, and they don't get to know as well, they don't know your body as well I mean you start with a new one and it may all be on the screen but it's not the same as them having advised you before and so on. I think the old fashioned way of one doctor is infinitely better, really." Female aged 73, Bradford

More details from patient questionnaires can be found in Appendix 8. More details from qualitative interviews with patients can be found in Appendix 9.

5. Patient outcomes

Summary of key findings

- No notable differences were seen between comparison and intervention groups in use of services
- There were no statistically significant differences at follow-up between intervention and comparison groups in change in psychometric scores from baseline *i.e.* no discernible effect of the intervention.
- Perceived health status and social support mechanisms were better in the intervention than the comparison group, at baseline and at follow-up.
- Statistically significantly better scores were seen in the intervention than the comparison group for all secondary outcome measures at baseline and at follow-up
- Secondary outcome scores changed in a positive direction for both intervention and comparison groups over time.
- Patients were largely unaware of any changes within Practices with regard to support for self care, although the appointment system was commonly reported to have changed (specifically triage).
- Most had not been given self care advice or were unaware of being given self care advice from anyone at the Practice.

## 5.1   Use of services

5.1.1 Data from patient questionnaires
Participants were asked about their future intended use and current (in the last six months) use of a list of services and other sources of support. They were asked to circle 'yes' or 'no' to indicate whether they intended to use or had used any of these services.
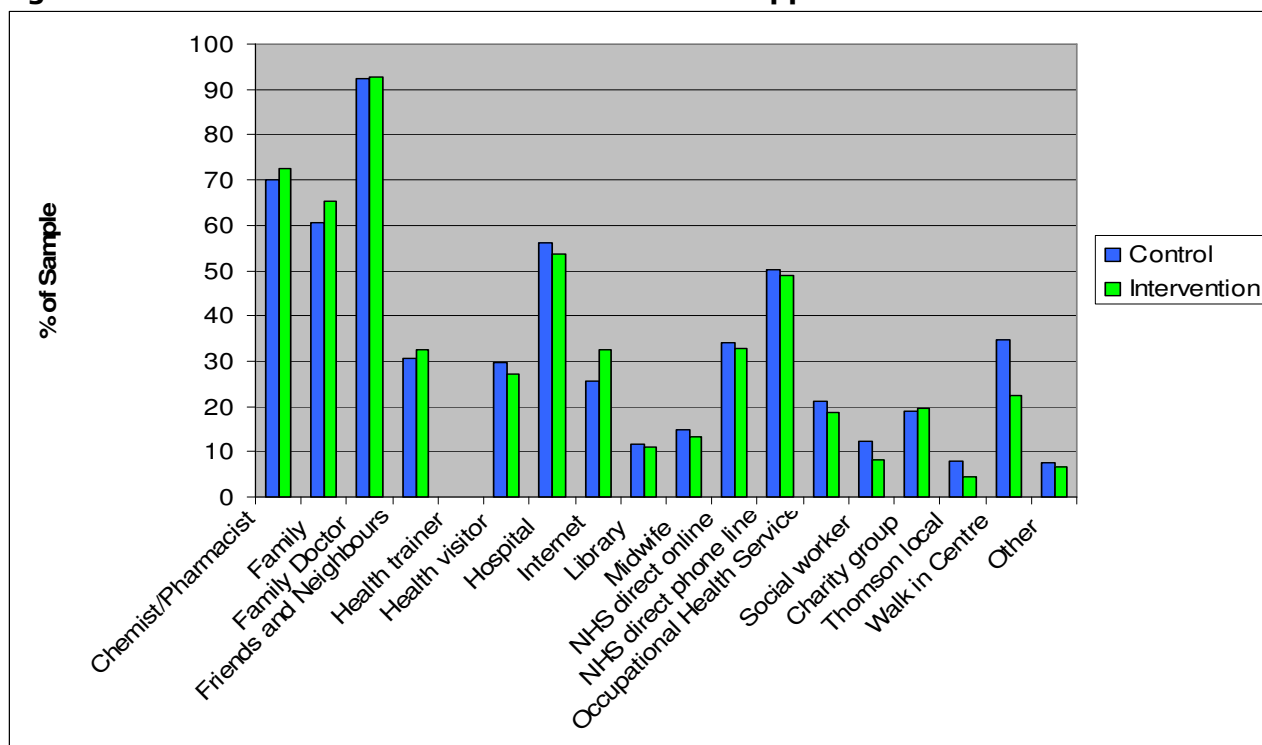

5.1.1.1   Baseline findings
Current use: At baseline 90% of participants said that they had visited the family doctor in the last six months, with more than half also having visited the pharmacist. Substantial numbers had also visited the hospital and/ or turned to family for support. A notable proportion also used friends or neighbours, the internet, or NHS Direct phone line for support. There were no notable differences between comparison and intervention groups in terms of which of the services they used. Figures 5.1 and 5.2 show the types of services participants reported using or planning to use; they do not show the number of times these services were used.

Figure 5.1   Baseline current sources of support
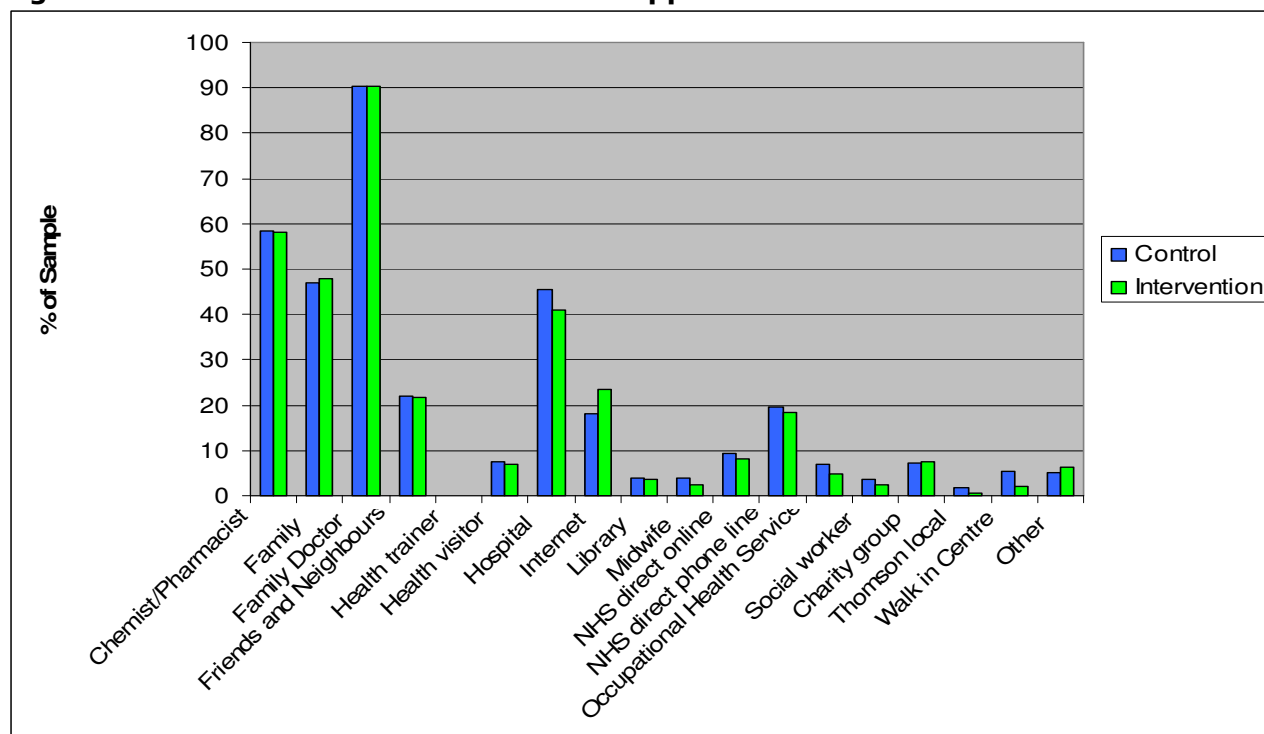
*Future use***:** At baseline, more than 90% of participants stated that they intended to use the family doctor in future, and more than half intended to use the pharmacist, family, the hospital and NHS Direct phone line. A substantial proportion of participants also intended to use friends or neighbours, health visitors, the internet, NHS online and Walk-in centres in future. A higher proportion of people in the comparison group Practices than intervention Practices intended to use walk in centres; this may be due to Leeds PCT, which has a walk-in centre, being part of the comparison but not the intervention arm of the study.

Figure 5.2   Baseline future intended sources of support

5.1.1.2   Six and twelve month findings

Current use: Findings were very similar to baseline measurements, except that notably more participants in the comparison than intervention group had used the hospital or NHS Direct phone line in the preceding six months.
Future use: Findings were very similar to baseline measurements.

5.1.2 Routinely collected data from Practices and NHS Direct

Baseline and endpoint means and standard deviations of service use over a six month period in intervention and comparison group are set out in Table 5.1.   When change in service use rates were displayed graphically it could be seen that, as expected, there was great variation by Practice, and Practices that did show significant change were just as likely to be in the comparison group as in the intervention group (see Figure 5.3, 5.4 and 5.5).

Table 5.1   Mean (SD) consultation rates over baseline and follow-up 6 month periods

| Consultation rate	Comparison Group		Intervention Group	
	Baseline	Follow-up	Baseline	Follow-up
GP	7.09 (5.32)	6.07 (5.32)	5.00 (5.42)	4.33 (5.85)
Other PHCP	1.86 (2.40)	1.61 (2.77)	1.48 (1.99)	1.60 (2.89)
Out of hours	0.03 (0.28)	0.02 (0.16)	0 (0.04)	0.01 (0.08)
A & E	0.02 (0.13)	0.01 (0.09)	0.01 (0.09)	0.02 (0.14)
NHS Direct	0.07 (0.33)	0.01 (0.10)	0.05 (0.28)	0.02 (0.16)

GP consultation rate

As expected there was great variation between Practices in changes in GP consultation rate (see Figure 5.3). For six out of the 11 Practices the 95% confidence interval of the mean change included zero, indicating no significant change in GP consultation rate. In five Practices a significant reduction in GP consultation rate between the two six month

periods was seen: three of these were Intervention Practices (Ilkley Moor, Streatham Place, Wilsden) and two were comparison group Practices (Manor, Earnswood). Some of these reductions were quite substantial: -1.33 visits in Ilkley Moor Practice; -2.37 in Manor; -2.33 in Streatham Place, -1.06 in Earnswood and -0.38 in Wilsden. These are reductions in the number of visits in a six month period, and if these were maintained over a 12 month period the first four would reach or exceed the 20% reduction thought to be clinically significant; however only two of these four Practices were 'Intervention' Practices so the effect cannot be said to be due to the intervention, as it is equally likely to occur in 'comparison group' Practices.

From the preliminary analysis it already seemed unlikely that being in an intervention Practice was likely to reduce GP consultation rate more than being in a comparison group Practice.

The results of the generalised linear model confirmed this hypothesis, indicating that the effect on GP consultation rate in a six month period of being in an intervention Practice rather than a comparison group Practice could range from a reduction of 1.75 visits to an increase of 0.25 visits (average was a decrease of 0.75 visits, but this was not statistically significant). The model was constructed to take into account Practice effects but as there were relatively few Practices and they varied in how the intervention was applied, we cannot be sure how much of any effect is due to the intervention and how much is due to the Practice.

Figure 5.3   Change in GP consultation rate by Practice
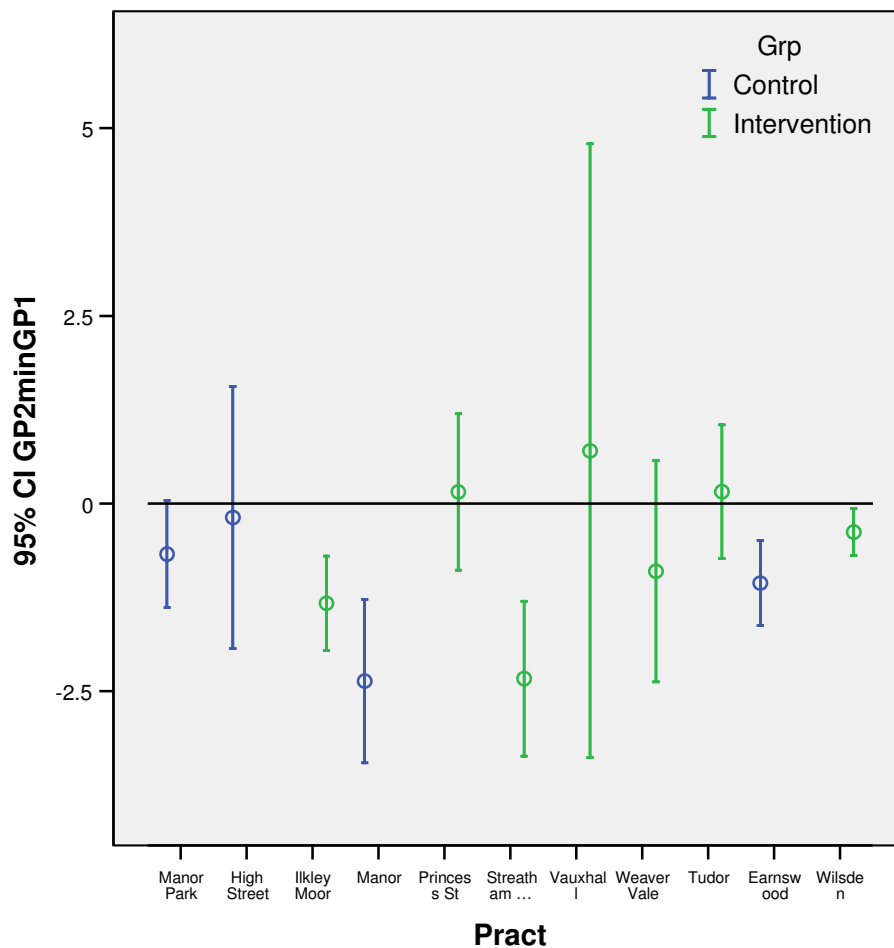
Other PHCP (not GP) consultation rate

At Practice level, changes in consultation rates with PHCPs other than GPs showed a similar pattern to changes in GP consultation rates. This may indicate that any changes in GP consultation rates were not due to altered patterns of consultation with other primary healthcare professionals (see Figure 5.4 and Figure 5.5). Again, the preliminary analysis indicated that being in an intervention Practice did not have a significantly different effect on PHCP consultation rate than being in a comparison group Practice.

The result of the generalised linear model confirmed this hypothesis, indicating that the effect on other PHCP consultation rate in a six month period of being in an intervention Practice rather than a comparison group Practice could range from a reduction of 1.2 visits to an increase of 0.24 visits (average was a decrease of 0.47 visits, but this was not statistically significant). Again, we cannot be sure how much of any effect is due to the intervention and how much is due to the Practice.

Figure 5.4   Change in other PHCP (not GP) consultation rate by Practice
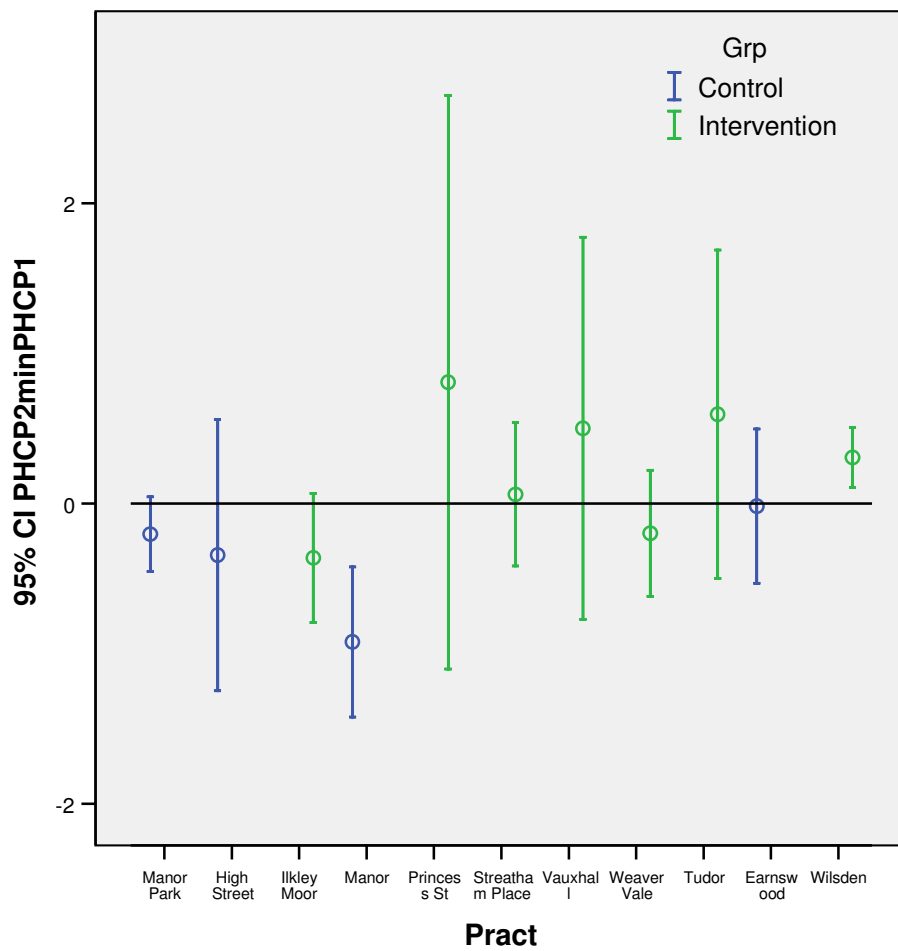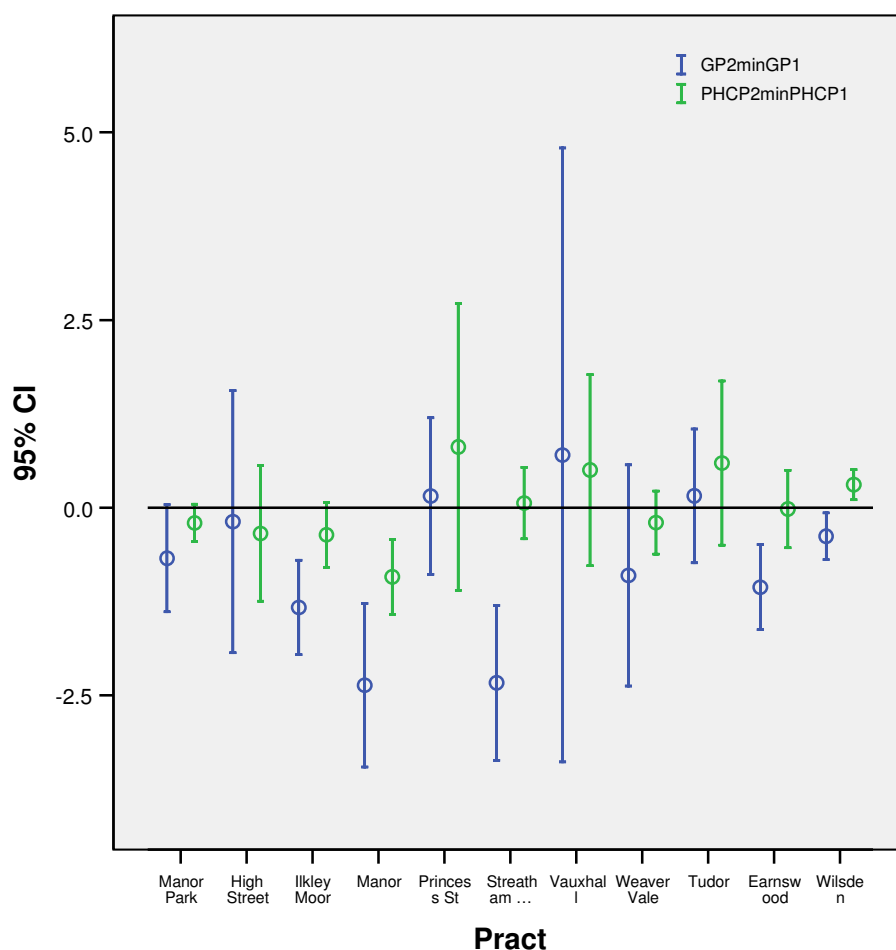
Figure 5.5 Change in GP and PHCP consultation rate by Practice, overlaid

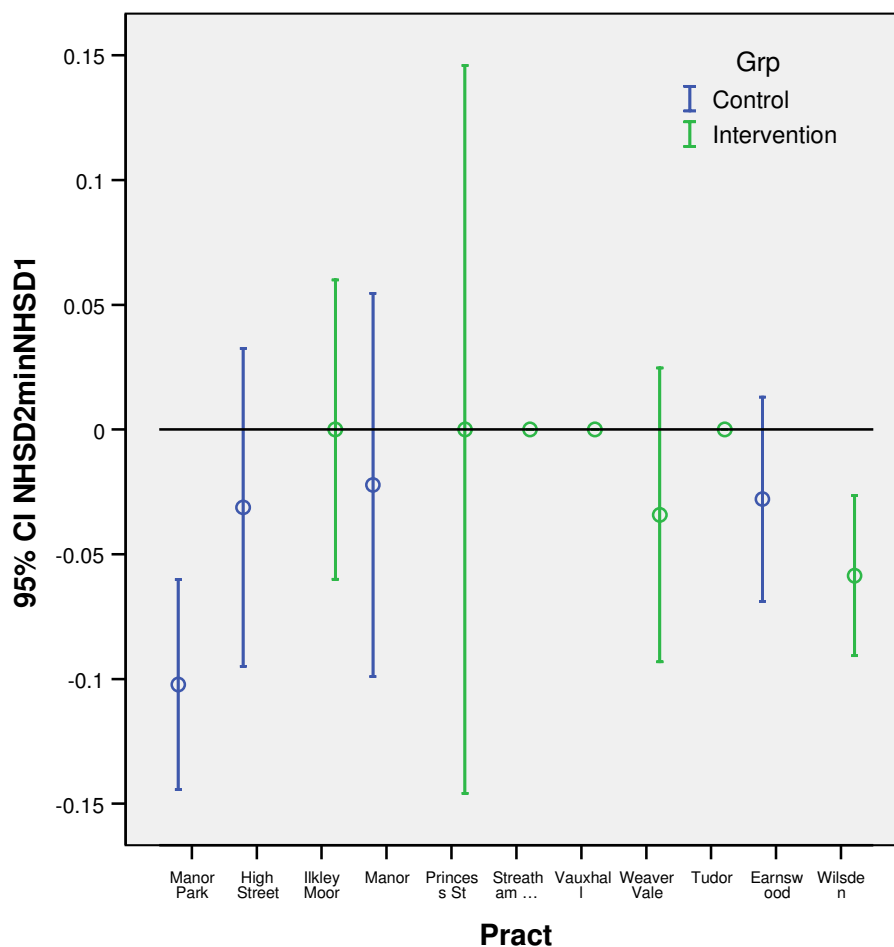**Changes in use of out of hours and A&E services**

Data on out of hours service use and visits to A&E were only available for a few of the Practices: this detail generally did not come out on automated data extraction but could be retrieved where data were manually extracted. This was however very time consuming so was only carried out in Practices where automated data extraction was not possible. There was not enough data to run the generalised linear model, but it can be seen from Table 5.1 that there was no statistically significant difference between groups.

Change in use of NHS Direct

Data on use of NHS Direct was collected centrally from NHS Direct for all study participants and verified against participant details.

Figure 5.5 shows the change in NHS Direct use by Practice. As for change in GP and PHCP consultation rates, nearly all of the 95% confidence intervals contain zero, indicating no significant difference between baseline and follow-up periods. Of the two Practices that do indicate a significant reduction, one is in the intervention group (Wilsden) and one in the comparison group (Manor Park). None of the Practices showed an increase in NHS Direct consultation rates.

The event rate was too low to run the generalised linear model.

Figure 5.5   Change is NHS Direct use by Practice

To summarise: Reliable estimates of consultation rates with GPs, other primary healthcare professionals and NHS Direct were obtained from routinely collected service use data held at Practices and at NHS Direct. Statistical analysis showed no statistically significant difference in consultation rates with GPs or other primary healthcare professionals or with NHS Direct between intervention and comparison groups. Data obtained for out of hours and Accident and Emergency consultations showed similar trends but could not be analysed in the same way due to missing data.

More details of routine service use data collection and analysis can be found in Appendix 10.

5.2   Secondary outcome measures – data from patient questionnaires

5.2.1 Perceived health status

At baseline, more than 70% of participants reported their health to be average or good. The distribution of responses was significantly different between intervention and comparison groups (chi-square p< 0.001), with more people in the intervention group reporting their health status as 'good' or 'very good', and more in the comparison group reporting their health status as 'poor' or 'very poor'. These differences persisted at six and twelve months.

5.2.2 Social support

At all timepoints, around 90% of participants agreed or strongly agreed with the statement "I have people I can rely on in times of trouble". However, the distribution of responses was significantly different between intervention and comparison groups (chi-

square p= 0.007), with more people in the intervention group agreeing or strongly agreeing and more in the comparison group strongly disagreeing. The difference persisted at twelve months follow-up.

5.2.3 Anxiety

The mean score at baseline on the anxiety subscale of the Hamilton Anxiety and Depression Scale (HADS) was 7.4 in the comparison group and 6.5 in the intervention group (see Table5.2). This corresponds to a diagnosis of no clinical disorder or 'normal'. The difference between groups of one point on a 21 point scale was statistically significant (p<0.001). Scores in both groups decreased slightly over 12 months follow-up, but the difference between groups was maintained (Table 5.2)

5.2.4 Recovery locus of control

The mean scores at baseline in the comparison group (29.8) and the intervention group (30.6) were statistically significantly different (p<0.001, mean difference 0.8 points, scale 9-45). The score in both groups is similar to the score in a small study of wrist fracture patients and lower (indicating a stronger external locus of control) than the score in a small study of stroke patients (Partridge 1989).The score in both groups increased (indicating a stronger internal locus of control) at six and twelve months, but the difference between groups was maintained (Table 5.2).

5.2.5 Perceived stress score

Stress scores were slightly higher (6.0) in the comparison group than in the intervention group (5.2) at baseline: again the difference was statistically significant (p<0.001). The score in both groups decreased (indicating reduced stress) at six and twelve months, but the difference between groups was maintained (Table 5.2).

5.2.6 Self esteem

Mean scores on the Rosenberg self esteem scale were slightly higher (indicating lower self esteem) in the comparison group (22.5) than the intervention group (21.3) at baseline and the difference was statistically significant (p<0.001, possible scores 10-40). Scores in both groups decreased slightly (indicating raised self esteem) at six and twelve months but the difference between groups was maintained (Table 5.2).

5.2.7 Wellbeing

Mean scores at baseline on the subjective wellbeing scale were 21.8 in the comparison group and 23.6 (higher life satisfaction) in the intervention group. The difference of 1.8 points was statistically significant (p<0.001, possible scores 5-35). Scores in both groups increased slightly at six and twelve months (indicating higher life satisfaction) but the difference between groups was maintained (Table 5.2).

Table 5.2   Mean (SD) group scores at 0, 6 and 12 months for psychometric and other scales

All values reported as mean (SD)

Scale	Baseline		Six months		Twelve months	
	Intervention	Comparison	Intervention	Comparison	Intervention	Comparison
HAD	6.47 (4.31)***	7.44 (4.62)	6.16 (4.11)***	7.12 (4.37)	6.08 (4.16)**	6.89 (4.24)
PSS4	5.22 (3.48)***	6.01 (3.44)	5.04 (3.33)***	5.77 (3.27)	4.85 (3.25)***	5.63 (3.10)
RSE	21.35 (5.45)***	22.54 (5.65)	19.25 (5.01)***	20.41 (4.87)	18.74 (4.96)***	20.13 (4.81)
SWB	23.61 (6.96)***	21.83 (7.03)	23.97 (6.98)***	22.05 (7.03)	24.03 (7.12)**	22.71 (6.79)
RLC	30.58 (3.82)***	29.80 (3.91)	34.29 (3.98)**	33.55 (4.24)	34.46 (4.24)**	33.56 (4.51)
HL	9.71 (1.32)	9.69 (1.33)	11.33 (1.81)*	11.06 (1.90)	11.42 (1.92)**	11.07 (1.93)

Key: **HAD** Hamilton Anxiety and Depression Scale (anxiety subscale); **PSS4** Perceived Stress Scale Short form; **RSE** Rosenberg Self-Esteem; **SWB** Subjective Wellbeing; **RLC** Recovery Locus of Control; **HL** health literacy
*** Difference between groups $p<0.001$; ** difference between groups $p<0.01$; *difference between groups $p<0.05$

5.2.8 Longitudinal analysis - MANOVA

Six and twelve month change scores were calculated by subtracting baseline scores from six month scores, and from twelve month scores, for the following outcomes: perceived health status; social support; anxiety; locus of control; stress; health literacy; future care; wellbeing; self esteem.

Mean six and twelve month change scores were calculated with standard deviations for intervention and comparison groups. The scores were compared between groups for each scale using a multiple analysis of variance (MANOVA) method. This statistical method corrects for the use of multiple comparisons, so that a spuriously statistically significant result is avoided.

The results of the MANOVA (Appendix 11) showed that there were no statistically significant differences in the six or twelve month change scores between intervention and comparison groups on any of the scales listed above.

5.3 Qualitative outcomes

5.3.1 Changes at the Practice

At six and twelve month follow-up patients were asked if they had noticed any changes in their GP Practice in the last six months.

- Several themes emerged, including changes to Practice premises, the introduction of equipment such as self service check in machines and blood monitoring machines, staffing changes and changes to appointment procedures. A small number of patients identified clinics such as a breast cancer clinic and a debt counselling clinic being available at the Health Centre, but it was not confirmed when these clinics were introduced.

- Only one person at six month follow-up and one person at twelve month follow-up identified changes in relation to the Practice's approach to supporting self care. A strong theme amongst participants was that no changes had been observed:

"No, none at all, except they've gone onto a new computer [booking in system]."
Female aged 68, Bradford

5.3.2 Changes to the way patients take care of themselves and their health

At twelve month follow-up patients were asked to report any changes to the way that they managed their health.

- The most common response to this question was 'no changes'. However there were a number of participants who reported that they had made changes to diet and exercise. Other changes expressed included smoking cessation, monitoring ones own health, changes to medication and lifestyle changes, however the reason for the implementation of change was often unclear:

"The condition I've got hasn't changed, so there's nothing they could do to change it really, or myself." Female aged 47, Cheshire

"I started the gym, and I've lost a bit of weight… because I think I need to lose weight and get healthy." Female aged 38, Cheshire

"I'm eating healthy food now, and I've,' cause I've been on steroids for quite a few months now and I've put quite a lot of weight on so I've now joined weight watchers." Female aged 68, Bradford

- Patients were not asked to mention any specific health conditions that had arisen, progressed or changed since the last interview. Despite this some participants did discuss such issues as treatment for sleep apnoea and heart bypass surgery. Such occurrences are therefore likely to have had a major impact on the way patients took care of their health.

5.3.3 Support for self care at the Practice

- The strongest theme in regard to self care support resources at the General Practice was a lack of awareness of self care materials and facilities and also a lack of discussion with Practice staff in regard to self care activities:

"Nothing about self care to the best of my knowledge, I haven't seen any leaflet or posters maybe that's because I'll need to wear my glasses. I don't think it has been encouraged. At least no one has spoken to me about it and no one seems to talk about it." Female aged 68, Lambeth & Southwark

- It is important to note that whilst a number of patients did state that they had noticed self care materials or discussed self care with Practice staff, these responses need to be interpreted in light of the range of different understandings of self care (see section 4.2.2.1). A number of interviewees also did not look at the information materials within the Health Centre:

"Not specifically as such, I mean the diabetic nurse, bless her, always talks about diet and losing weight... just as part of a general background I think." Male aged 52, Bradford

"Not really about self care, though she has seen leaflets about osteoporosis and how to go about that but not anything about self awareness." Female aged 39, Lambeth & Southwark

- Of those participants who did report that they had noticed or discussed self care at the Practice the most common response was in regard to leaflets and posters. A small number of patients also talked about the introduction of a blood pressure monitoring machine (for patients' use) into the Health Centre:

"They have lots of leaflets round about, blood pressure and, you know cholesterol and heart disease and you know men's health and women's health, lots of leaflets like that." Female aged 33, Cheshire

- Patients showed varying levels of readiness to enter discussion with Practice staff in regard to issues relating to self care. Whilst a number of patients stated that they would be open to discussion and advice relating to methods of self care almost as many stated that they would not want a member of Practice staff to impart advice relating to self care upon them:

"I don't think there's anything more that I don't already do." Female aged 28, Cheshire

"I don't think it would be needed, because I think we know one another so well anyway that we know if I go to the doctor, if I go to see her it's something that I need to see her about." Female aged 59, Lambeth & Southwark

- At twelve month follow-up patients were asked whether their Practice encouraged self care. There was no overriding response to this question, with a number of patients stating that their Practice did encourage self care, a number of people stating that their Practice did not and also some participants who were unsure. There was a suggestion that some patients who indicated that their Practice did support self care reflected expectation rather than personal experience:

"I would imagine they would, to be honest but how much they do, I don't know." Male aged 71, Cheshire

Many patients had not used any self care support provided by their Practice, however once again patient perceptions of engagement may have been affected by differing levels of understanding of the concept of self care (see section 4.2.2.1). Of the respondents who did declare use of self care provided by the Practice, the most common theme was the provision of leaflets by Practice staff, other responses included use of a blood monitor machine, taking advice and use of GP print outs:

- *"I've been given information when I'm at the GP's about, obviously the way you define self care, I've been given information but I think that 's been in existence all the time, any good GP will always be giving you information that you can follow-up on."* Female aged 41, Lambeth & Southwark

5.3.4 Effects of being in the study
- Whilst a large proportion of patients did not perceive that participation in the study had influenced their behaviour, some participants believed that it may have increased knowledge of the concept of self care. There was a perception that the study may have affected knowledge and use of available self care support services and some patients believed that filling out the questionnaires and being involved in the interviews brought key issues to their attention:

"Not really, I don't think it's affected me at all really... apart from when I do get the questionnaire, then I think oh you know, I may think about self care for myself more, maybe try and improve my health a bit." Female aged 18, Lambeth & Southwark

"Well it does kind of make you think… they should be doing that little bit more for you, it does really open your eyes a little bit more, make you aware." Female aged 63, Cheshire

6.0 Summary of evidence

Following on from the NHS Plan (DH 2000) the 2005 government report "Self Care - A real choice, Self Care Support – a practical option" (DH 2005)[4] gave added impetus for the Health service as a whole to embrace the notion of self care and self care support as a key resource in addressing the pressing health challenges within present day society.

Self Care in Primary Care is part of a programme of pilot initiatives commissioned by the Working in Partnership Programme following the negotiation of the General Medical Services Contract with the intention of reducing consultation rates in general practice and beyond.   This evaluation sought to understand the implications of running a self care skills training programme for professionals in the Primary Care sector. To achieve this goal evidence has been gathered on a range of different indicators to map, over the course of a year, the changes that have occurred within a specific patient group, the Practices themselves and from the perspective of the broader health economy.

The process evaluation[5] of the implementation of SCinPC involved interviews with key stakeholders and interviews and questionnaires with the health care staff trained through the programme. The patients' perspective was obtained through detailed questionnaires completed at baseline, 6 months and 12 months, alongside interviews with a sub-sample at the same time periods. The impact of the programme on patient outcomes was determined through the analysis of routinely collected data.

This multi-method approach has produced data of breadth and depth, giving a unique insight into the lives of people who have been identified as 'frequent attenders' and how they have been influenced by change at the Practice level. The study has also tracked the implications of trying to introduce new ways of working with patients and primary health care professionals.

The richness of the data collected on patients has created a unique insight into how frequent attenders see their health and well-being and how that translates into actual health care usage. The majority of studies into frequent attenders have tended to focus onto those who are categorised as extreme users *i.e.* over 25 times a year, whereas this cohort was initially identified as being moderately frequent users (between 8 and 11 visits per year).

The data from the Practices raises important considerations into the complexity of initiating change within Primary Care. The evaluation of the impact of the training programme demonstrated processes at work that show that transferring ideas into reality requires the co-operation of many different players, suggesting that if the introduction of a policy to support self care is to be successful there must be buy-in from health care professionals in the community. This factor was important for this study as issues concerning the way that the SCinPC initiative was received within the Practices had repercussions on the findings of the evaluation, especially those that relate directly to the patient experience. It was not possible to get a reasonable sample of Health Care staff to participate in the evaluation, but those that did, along with the interviews with the Self Care skills trainers and others involved in the implementation of the initiative reported that there were difficulties in getting staff and in particular GPs to engage with the programme, either at the training phase or at the implementation phase.

A further key finding was that though practitioners and health care staff could see and appreciate the potential benefits of such an initiative, a year was too short for the changes to feed through to patients. This context is important to remember when reading this report.

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[4] Please see Appendix 1 for a literature review on Self Care
[5] Please see Appendix 12 for an overview of the issues relating to evaluation methodology, patient recruitment and generalisability of findings.

This section of the report draws together all the evidence collected within the study and presents the key findings through addressing the research questions posed at its commencement.

6.1   Has Self Care decreased primary care consultations?

The primary research question for this study was "Is the Self Care for Primary Health Care Professionals initiative associated with a decrease in primary care consultations?" and directly linked to a desire to see a measurable reduction in GP consultation rates for those identified as frequent attenders (defined as 8-11 consultations in a year).   The primary outcome measure chosen was: *Reduction of 20% in usage of primary health care services as measured by GP consultations in frequent attenders comparing the 6 months prior to study to final 6 months of the study period*.

This primary outcome was not realised during the time this study was conducted.

The patients interviewed through the course of the study had limited or no recollection of any changes that could be directly attributed to the introduction of the policy to support self care.

6.2   What impact does the SCinPC initiative have on patterns of self care and service utilisation?

There was no evidence from the routine data, the questionnaires or from the interviews that there has been any major change in the way the patients performed self care or utilised health service provision.   There was an increase in health literacy, but this was mirrored by the comparison group and perhaps was an artefact of being recruited onto the study and the completion of the questionnaire.

6.3   Does the SCinPC initiative lead to a reduction in general practice workloads?

The initial design of this evaluative study was predicated on an assumption that routinely collected data at practices would be easily retrievable from PCTs. This proved to be not the case and in order to obtain the data an extremely complicated and labour intensive process of data extraction was required at Practice level. There are many different information systems in use and few of these are able to extract data in a form useful either for this study or for meaningful workload analysis at the Practice level. This is a key finding of the research study in itself as it suggests that these Practices have not previously questioned service provision and therefore would be unable to determine if any changes in practice had an impact on patient service usage behaviour. This view was supported through the interviews, and an important finding from the study is that few Practices have previously attempted to analyse their own workload, with the SCinPC workshops providing the first opportunity for many to consider what their true pressure points are within the system and to start to identify how they may be managed better.

This did result in many considering using a system of triage, either by their Practice nurses or the receptionist, though this has to be recognised as a system of demand management rather than the implementation of a policy to support self care. In addition, not all Practices that considered triage implemented it. Furthermore, triage alone may not lead to a reduction in GP consultation rates: of the three Practices that specifically mentioned triage during interviews with staff, only one (Ilkley Moor) saw a statistically significant reduction in GP consultation rate over the course of the study. One (Weaver Vale) saw a non-significant drop in GP consultation rate and the other (Tudor) saw no reduction. Consultations with other PHCPs increased in Tudor Practice, although not significantly, and decreased (non-significantly) in the other two Practices, indicating that triage, as well as not leading to significant decreases in GP consultations, did not lead to significant increases in consultations with other PHCPs either. To put these findings into

context, the two largest reductions in GP consultation rates were seen in Manor Health Centre (a 'comparison' Practice) and in Streatham Place, an 'intervention' Practice in which no new activities seemed to have taken place as a result of the initiative.

6.4 Does this initiative lead to changes in primary healthcare professionals' knowledge, attitudes and beliefs relating to self care?

It was apparent from the interviews with the PHCPs that many saw themselves as already having a good understanding of what self care means and that they felt they were currently supporting and promoting self care with the patients. The majority reported that they routinely spoke to patients about their lifestyle, diet and exercise, care of minor illnesses, care of long term conditions, signposting and smoking cessation. There was also recognition that supporting and promoting self care was to the benefit of the patient, with regard to their physical and emotional well-being and in their empowerment.

Nevertheless there was realisation for some of those who completed the exit questionnaire and from the professional interviews that through attending the workshops they developed an understanding around the concept of self care, and that current practice to support self care could be extended further.

6.5 What impact does the initiative have on the health economy and culture within Practices and the Primary Care Trust (PCT)?

What became apparent through the interviews with the staff was that to achieve the goals of supporting self care there would need to be a fundamental shift in the care of patients within Primary Care. These changes would have to occur at all levels and at all phases of the process, from priorities at PCT level, to the way the Practice assesses and manages its workload through to the way that the consultations with patients are conducted. Few national initiatives have attempted to influence how health care professionals interact with patients, and it is this component that can be seen within this report to have been the most problematic and therefore contentious.

What emerged very strongly from the interviews we were able to undertake with the professionals and Practice staff and with the Stakeholders was that this initiative needed quite a major shift in culture at the Practice level for it to work effectively. A further important factor that characterises this initiative is that it has the potential to directly influence what happens during the consultation itself. The findings suggest that it is the General Practitioner specifically who has to take a lead in directing the patient towards being better able at self caring and to signpost them towards further self care information and skills training.

An issue that has relevance here is the use of receptionist staff to undertake triage of patients at initial contact with the Practice. There were receptionists and patients who felt unsure about this move. From the receptionists there were doubts about their ability to correctly identify those most in need and worries over possible litigation if mistakes were made. The patients found the disclosure of personal information to the receptionist problematic.

6.6 What changes can be seen within the target population in relation to their self care activities, beliefs and healthcare behaviours?

The data from the questionnaires and interviews tends to suggest that for the majority of patients recruited onto the study there has been no change in the way they self care or in the way professionals provided them enhanced support for self care. The only real change many saw in the way care was provided within the Practice was with regard to the instigation of nurse or receptionist lead triage.

6.7 What changes can be seen within the target population in relation to health outcomes?

From the questionnaire and interview data, there were no significant changes seen within the intervention group with regard to changes in health outcome.

Routinely collected data on A&E use was limited in its availability, but the data that was obtained showed no significant change from baseline and no difference between intervention and comparison group at follow-up.

6.8 Is the SCinPC initiative feasible, relevant, appropriate and acceptable to major stakeholder groups?

The SCinPC initiative was seen as fitting very well with the aspirations of the PCTs and the stakeholders interviewed from the PCTs were all very supportive of work being undertaken, through there was general agreement that its introduction into Practices would be challenging.

There was a feeling that this initiative would eventually become more the domain of the rest of the Practice staff rather than the GP's due to their perceived reluctance to embrace change and due to the nurses' broader, more holistic, view of the patient. There was also a realisation expressed that it would take a long time for the changes to be realised and for any benefits to come through.

6.9 What are the facilitating factors and barriers that influence the process of successfully implementing, embedding and sustaining the SCinPC initiative?

Facilitators
There were many PHCP and Practice staff who saw the benefit in having better management of workload and that SCinPC provided the structure for that to happen.

The essence of Self Care can be found within all major health legislation since the Alma Ata accord in 1978 for 'Health for All'

This initiative was part of a package of interventions that was specifically requested by the GMC as part of the renegotiated GP contract, therefore there should be buy-in from all levels of the medical profession.

There is a greater push for the public to have better health and the development of personal Self Care is an important aspect of achieving this goal.

The general impression is that the clinical teams within Practices have found the training days have helped improve their team working

Barriers

The introduction of SCinPC appears to warrant a culture change within Practices and among patients, which will take more time to realise than was available for this pilot. Data from the professional and health economy interviews revealed a reluctance to support and promote self care within Practices. While many professionals, rightly or wrongly, assumed that they were already supporting and encouraging patients to self care, others were disinclined to shift any responsibility towards the patient. There was a concern among some professionals that the promotion of self care was a risky strategy potentially sending out the wrong message to patients, and leaving surgeries and staff members open to censure should patients' health suffer.

The initiative suffered from being introduced at a time or organisational change and restructuring in primary care.

Competing financial pressures at both PCT and Practice level were perceived by stakeholders as a key barrier to implementation of any policy to support self care. A lack of investment from PCTs was cited as preventing a roll out on a wider scale. At Practice level the absence of any immediate financial reward was cited as preventing staff being released for the training or for changes in the infra-structure. Professionals perceived the support and promotion of self care to be time and labour intensive and requiring key skills. It was felt that competing financial pressures did not enable Practices to devote time or resources to train staff and ultimately support and encourage patients to self care.

Stakeholders and PHCPs expressed the need for a cultural change among patients. There was a perception that patients were dependent upon their GP, and did not like being diverted to other health care professionals for consultation. There was a suggestion among some professionals that changing patients' attitudes regarding health care would be a slow process, and successful implementation of a programme to support self care would require gradual changes in patients' health care behaviours. Despite patients' positive attitudes towards the concept of self care, patient interviews somewhat corroborated this view. Patients' perceptions of the quality of support services, other than from the GP may be an important factor in preventing the successful implementation of policies to support self care. For many patients the general practitioner was cited as the first port of call when health care support was required, this may in part be due to patients' lack of confidence in other support services such as NHS Direct or pharmacists.

7. Discussion points

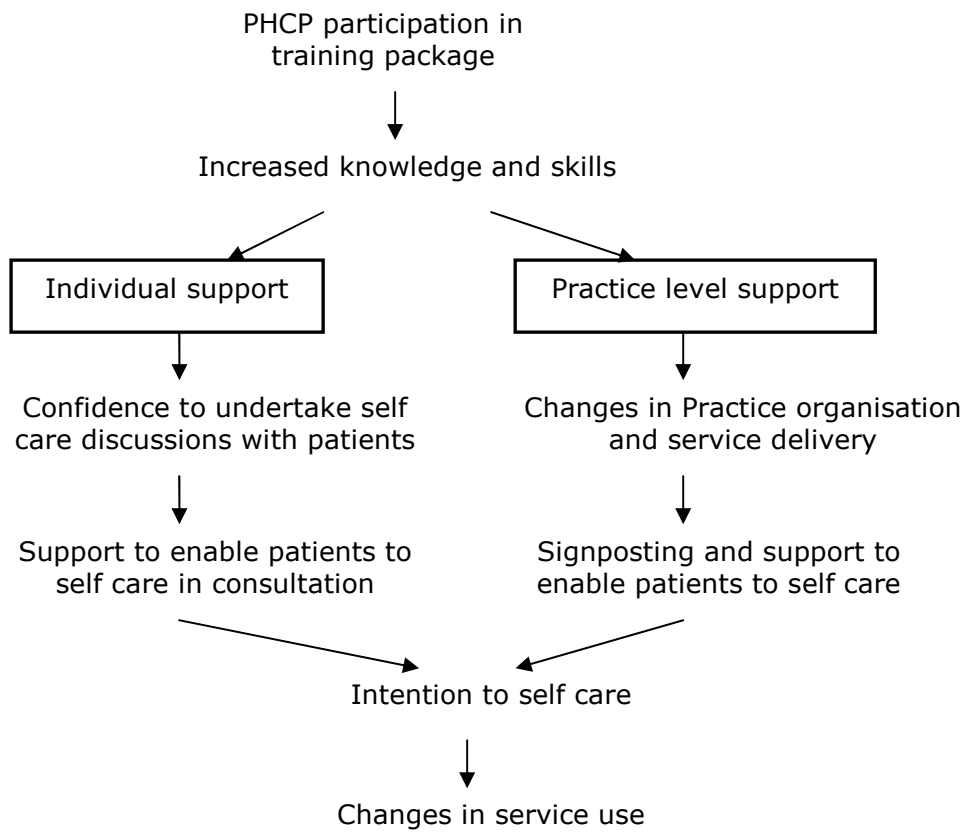See Appendix 12 for a full discussion of the findings and implications of the research.

7.1 Interpretation of results

- The findings from this study have to be recognised as emanating from a pilot where there was patchy uptake of the initiative and therefore the achievement of the primary outcome would be difficult to demonstrate.
- With limited recruitment of health professionals to both the initiative and the evaluation the representativeness of the sample may be questioned (see Appendix 12).
- Recruitment of the patient sample was also problematic as this was the first attempt to engage patients in a complex longitudinal study; this may also have implications for representativeness and generalisability. (see Appendix 12).
- The patients taking part in the study were a selected group who frequently attended the GP Practice. This group may have had particular characteristics that represented barriers to change in their consulting behaviour.
- The concept of self care can be confusing for some, and the beliefs of those taking part were varied and there were a number of influencing factors.

7.2 Theoretical model

It became clear from the interviews with stakeholders and professionals that the theoretical model of interventions effects proposed in Figure 1.1, which focussed on individual support from the primary healthcare professional to the patient, should be amended to include Practice level support as a parallel intervention (see Figure 7.1). What seemed to have happened in the implementation of SCinPC was that the focus of change had been on the Practice based support arm and not on the individual level support arm. Changes need to be made to both arms in parallel to implement the intervention successfully.

Figure 7.1   Amended model of effects of intervention

PHCP participation in
training package

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Increased knowledge and skills

Individual support

Practice level support

Confidence to undertake self
care discussions with patients

Changes in Practice organisation
and service delivery

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Support to enable patients to
self care in consultation

Signposting and support to
enable patients to self care

Intention to self care

↓

Changes in service use

8.   Conclusions

This study has evaluated the pilot phase of an initiative that would take some time to be fully realised. An underlying theme that emerged through the interviews with stakeholders and professionals was the realisation that continuing health care delivery on along the existing path was not sustainable and that ways had to be found to reduce the dependence patients had on the General Practice and to improve the self caring skills of the population.

This was the first attempt to introduce a change within primary care that would have an effect on the GP consultation itself. It was recognised that the successful introduction of Self Care into Primary Care required the very culture of GP practice to alter and this was a challenge that would take more time and more resources than this current pilot could call on.   Even in PCTs that had competitively fought to take part in the initiative it was still problematic to find Practices that were willing to engage, would allow the facilitators in to run the training sessions and could contemplate, let alone initiate, those aspects of the self care philosophy that are required to get systems and cultures altered in practice to achieve change in patients' behaviour. This in the patients, who generally, despite being frequent attenders, felt their own self caring skills were good and in many patients, who while supportive of self care, did not identify a need to change their behaviour or expect GPs to change.

For the initiative to be successful, changes needed to be made at organisational level (e.g. PCT backing and demand management within Practices), at consultation level between primary health care professionals and patients, and ultimately in individuals' behaviour, both of professionals and of patients. There were attempts made in some Practices to initiate changes, but these seem to relate more to demand management issues (*i.e.* triage) rather than supporting the development of self care within individuals.

No significant changes were seen in study participants' use of health services, psychometric scores or self care beliefs or behaviour during the course of the study.

Nevertheless, there were promising signs that despite this major initiative being introduced alongside wholesale reorganisation and upheaval in the PCTs, Practices were influenced by the training package and many were as a result engaged in examining their systems for supporting self care within their patient population.

9. References

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