

Year of Care: the key drivers and theoretical basis for a new approach in diabetes care

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Abstract

The Year of Care initiative aims to transform the annual review into a collaborative care planning consultation based on a partnership approach. It has been piloted across three centres in England.

This paper describes the key drivers that created the impetus for the development of the approach. The care planning model developed by Year of Care, 'The House Model', is presented and the process of the care planning consultation described. The theoretical underpinnings and supporting evidence are presented for each of these as well as the philosophical assumptions and values that underpin the programme. Copyright © 2012 John Wiley & Sons.

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Key words

Year of Care; care planning; partnership approach; self-management

Introduction

Diabetes is a lifelong condition that affects over two million people and costs around 10% of the NHS budget.¹ People with diabetes make all the decisions about their health on a day-by-day basis and need a health service that supports them more effectively in this endeavour.

The Year of Care (YoC) initiative aimed to improve services to support self-management (SSM) by changing the annual review into a collaborative care planning consultation based on a partnership approach. YoC was piloted across three centres in England chosen for specific areas of strength and expertise. An iterative feedback process ensured all learning was collated alongside an external evaluation.

From the outset the clinicians involved were interested in the theoretical underpinnings, philosophy and supporting evidence for YoC which is understandable when considering major alterations to practice. This paper sets out to describe the main theoretical influences, guiding principles, supporting evidence and key drivers for YoC.

The key drivers for Year of Care and guiding principles

The main drivers for change came from evidence that questioned the efficacy of traditional methods,² service user surveys^{3,4} and national policy,^{5–10} as well as a developing theoretical/conceptual base which

offered positive solutions to the problem based on changes to consultation and relational style.^{11–13} Clinic infrastructure would also need to change to support staff working in new ways.¹⁴

These drivers mirror the key components of the Chronic Care Model (CCM).^{15,16} Better outcomes result from a proactive and systematic service working in partnership with an empowered and activated individual, i.e. someone who has gained the knowledge and skills required to manage their condition and is ready to do so. Support for self-management (SSM) is the intervention with the strongest link to improved outcomes¹⁷ within this model.

SSM interventions focusing purely on delivery of information can improve knowledge, but have variable effects on glycaemic control, blood pressure and weight.² Thus, knowledge attainment alone is not sufficient to achieve and sustain lifestyle change.^{2,13,14} Several reviews have demonstrated that theory based self-management training programmes with integrated behavioural and educational elements improve self-care behaviour and diabetes outcomes,^{2,12} and are most effective when tailored to individual needs.¹⁶

User feedback has been a driver for change. Ninety percent of people with a long-term condition (LTC) expressed an interest in being

more active self-carers. However, over 50% who had seen a health care professional in the last six months had not been encouraged to self care.^{5,18}

A national diabetes review⁴ found that only between 34% and 61% of people had agreed a plan to manage their diabetes, and even fewer reported having a discussion about their personal goals (23–58%); see Figure 1.

Standard 3 of the Diabetes National Service Framework^{8,9} highlighted care planning as the focus for a 'partnership in decision making'. The importance of care planning for those with an LTC has also been emphasised in national policy; 'no decision about me without me'.¹⁹

The diabetes community developed a care planning model¹⁰ and reviewed the evidence base for its components.¹⁴ The YoC programme has successfully demonstrated what is needed to embed this in routine care for people with diabetes.

The care planning model

The YoC pilot sites identified a range of activities needed to support care planning as summarised in the 'House Model' (Figure 2) which is both a metaphor and checklist for the YoC approach to care planning. The House Model^{20,21} places the consultation within a framework: the walls represent the engaged informed patient and health care professional committed to partnership working. The roof highlights the administrative functions needed for the process to run smoothly. Changes in skill mix and resources to be commissioned are the foundations. The components of the House Model closely reflect the theoretical base for SSM.

The care planning consultation

(See Figure 3.) The care planning consultation is: 'a process which offers people active involvement in deciding, agreeing and owning how their diabetes will be managed ... underpinned by the principles of patient-centredness and partnership working'.¹⁰

Information gathering occurs at a first visit when biomedical tests are completed, often by a trained health care assistant; the person is

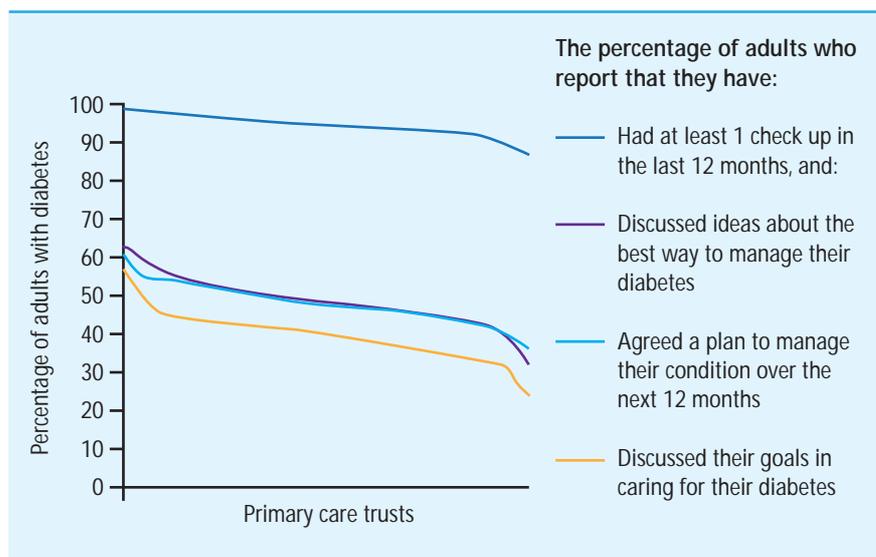


Figure 1. Percentages of adults with diabetes who report having check ups and planning their care, across primary care trusts in England. (Reproduced from 'Managing Diabetes'; © 2007 Commission for Healthcare Audit and Inspection)⁴

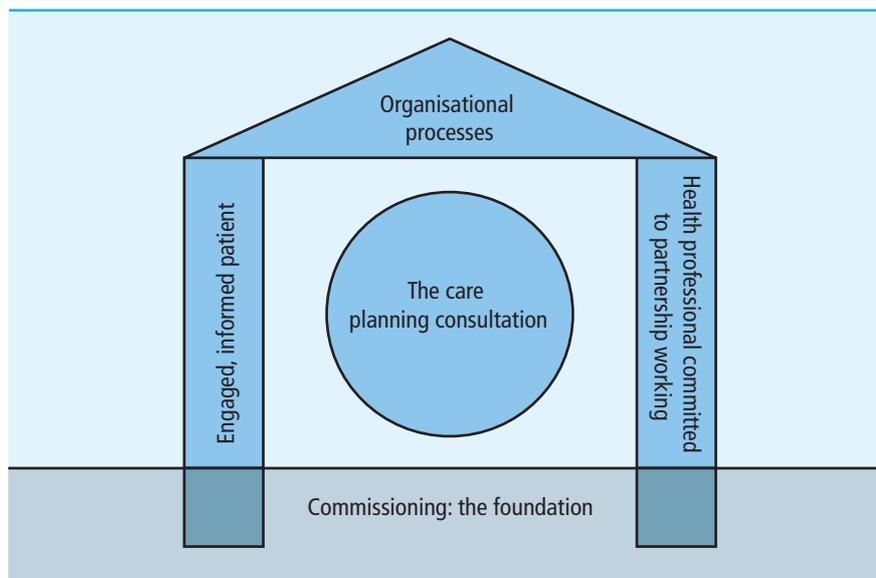


Figure 2. Year of Care 'House Model'

then asked to consider their aims for the consultation and the issues in their life that impact upon their self-management.

Information sharing is the person receiving their biomedical results, usually by mail prior to the consultation, with a reflection tool to use in order to prepare for the care planning consultation. This stage is fundamental to YoC care planning and is at the heart of the 'informed, engaged patient'.

The care planning consultation itself has a series of stages where both the person and the health care professional share their thoughts,

concerns and goals, and actions can be discussed and agreed. The outcomes of the consultation are documented in an agreed and shared care plan promoting ownership and shared responsibility.

Much emphasis has been placed in policy documents upon the care plan: the final record of the consultation. YoC care planning places greater importance on the process of the conversation between the person with diabetes and the clinician.

There has been a considerable shift in consulting styles in the last 20 years from the traditional medical model which saw the health care

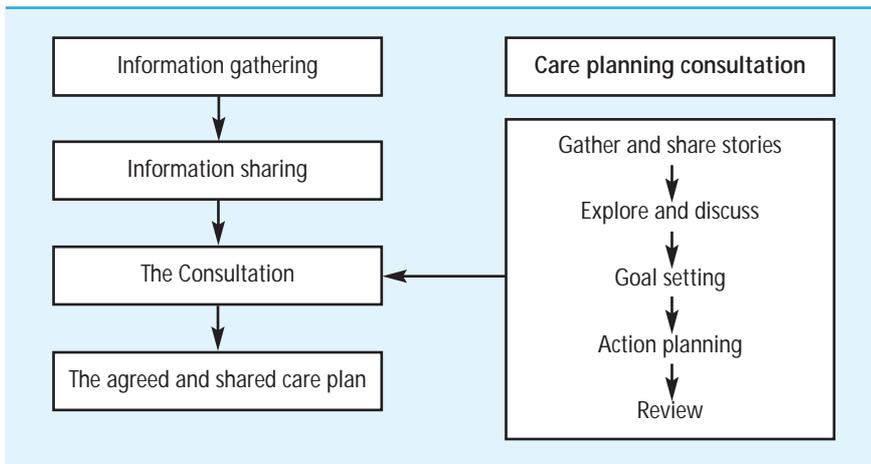


Figure 3. Care planning: the overview

professional as an authoritative problem solver and the patient as a more passive recipient.¹³ Consultations now recognise the central role of the person with the LTC as decision maker, and incorporate skills such as rapport building, active/reflective listening, clarification of concerns, and summarising and developing a shared agenda.^{13,22}

However, to embrace fully a partnership approach there needs to be a fundamental shift in how the roles of the participants are viewed, so it is truly seen as a meeting of experts, each with a story and agenda to share.

Theoretical underpinnings and supporting evidence

'Information gathering' and 'information sharing'. The Healthcare Commission revealed that 61% of people would like their HbA_{1c} result in writing whereas this only occurred for 10–13%.³ The conversations in consultations were reported to be a source of frustration for patients and one-quarter of them say they have never talked to a health care professional about their overall aims.²³

Those with immediate access to their HbA_{1c} result have improved glycaemic control at six- and 12-month follow up despite health resource use remaining unchanged.²⁴ Visual personalised feedback of biomedical results and suggested goals that encourage seeking of information lead to significantly lower HbA_{1c} levels,²⁵ and patients who knew their HbA_{1c} level had a better understanding of the meaning of

these values as well as how to manage their diabetes.²⁶

Evidence also suggests that increased patient conversation time can occur without increased overall consultation time.²⁷

'Care planning consultation.' In YoC, the engaged informed patient meets with a health care professional committed to partnership working. The walls, foundation and roof of the House ensure this takes place within an environment that promotes a trusting, honest, non-judgemental relationship with a focus on diabetes self-management.

The YoC consultation has a theoretical conceptual base with supporting evidence.^{11,28,29} Figure 4 shows the YoC care planning consultation mapped against other well known models. In the YoC model, the person with diabetes has information about living with the condition to bring to the consultation, and it is they who will decide on the goals and actions required.

Reaching a shared perspective on the priorities of care and treatment goals encourages a sense of control.³⁰ The person's focus is often immediate life situations and promoting change should involve the identification of his or her internal and external motivating factors as well as barriers. Gathering and sharing stories is a form of agenda setting as it allows the coming together of the patient's and the health care professional's concerns and aims for the consultation.

There is now a growing acknowledgement of the importance of

continuity of care and the therapeutic relationship^{16,31} to outcomes, but a lack of consensus about how it is to be defined or measured.³² A positive therapeutic alliance is related to consultations with clear goals, tasks and stronger bonds.³³ 'Explore and discuss' allows for clarification about what is important to both practitioner and patient, the goals and the task at hand, thus promoting a more positive working alliance. This stage encourages exploration of health beliefs and specific self-management behaviours.

Social cognition theory³⁴ suggests that high levels of self-efficacy (a belief in your own ability to perform a task) contribute towards the likelihood of participation in the activity. Those with high self-efficacy are more likely to perceive difficult tasks as something to be mastered rather than avoided. Diabetes-specific self-efficacy can be enhanced by focusing on self-management successes and goal setting.^{35,36}

Addressing barriers to self-care and exploring values, motivations and goals are effective facilitators of improved metabolic control. Patients' behaviours are mediated by their health beliefs, and exploring this is important when promoting behaviour change.³⁷ Issues related to low mood, anxiety and other psychological difficulties can also act as barriers.

Ambivalence is common in consultations, particularly when considering behaviour change.³⁸ Motivational interviewing³⁹ and health behaviour change counselling have been used with some success in diabetes. Motivational interviewing demonstrates treatment effects superior to traditional advice and a recent meta-analysis of 119 studies showed a small positive effect.^{39–42} Further research is required to explore its feasibility in routine consultations. Training in such techniques results in increased empathy, open questions, reflective listening and reduced unsolicited advice from the practitioner,⁴³ all factors key to a positive working alliance.

Philosophy

YoC care planning has a clear, defined and documented philosophy which is an essential requirement for any programme of

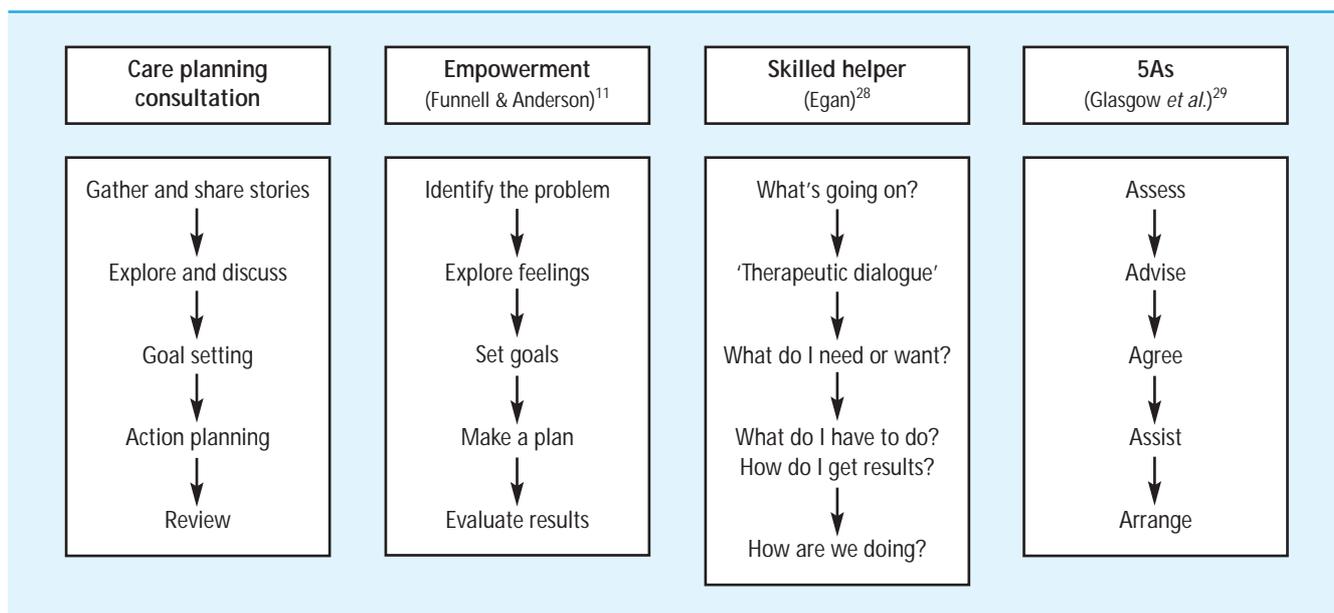


Figure 4. The Year of Care care planning consultation mapped against other well known models

SSM.^{10,20,21} A stated philosophy ensures clarity about the assumptions and values that underpin the programme and is widely employed in any scientific endeavour.⁴⁴ Rather than operating unconsciously, the assumptions and values are overt and can be examined.

The philosophy determines the style of the programme and the behaviours of the health care professionals. YoC's style of working may require some health care professionals to develop an enhanced skill base in order to be effective agents of change to support people with long-term conditions such as diabetes to self-manage. For some, this will require a shift in the way they perceive their role and such change can be difficult.¹¹

Patients' perspectives are congruent with this, including the desire to be seen as an individual, rather than 'just another person with diabetes', and the wish to be seen as an expert in their diabetes management.⁴⁵

Summary

Care planning is a new intervention devised to address the problem of lack of support for self-management in people with diabetes. The YoC programme aimed to identify how this could be achieved in routine care (both primary and secondary) based on the best evidence available.

Throughout the programme the new approaches were subject to evaluation and the beneficial effects for staff as well as patients are summarised in a companion paper. The learning and more practical application of the approach are discussed in more detail in the Final Report of the Year of Care pilot project found at www.diabetes.nhs.uk/year_of_care/ (2011).

This paper links the interventions of the YoC care planning approach with the key evidence from an extensive literature. The core elements are:

- A personally tailored approach.
- Using structure based on theory within the consultation to identify an individual's needs, issues, concerns, goals and actions.
- Managing the tension between what the health care professional and the person with diabetes may view as good outcomes.
- Ensuring a supportive organisational framework.

It is about ensuring the consultation is seen as the essential tool in facilitating self-management at the same time as making best use of the array of modern biomedical improvements, and acknowledging that this takes skill and practice linked with tailored training.

Currently, at least a third of consultations in diabetes do not support self-management and waste

Key points

- Both policy and a growing evidence base highlight a need for a fundamental shift in the way that care is delivered. From an 'expert' led consultation to one based on a partnership approach
- Many models direct us to what might be the key components and process of a consultation. For some practitioners this will require a major shift in their philosophy of care and the manner in which they engage with the person with diabetes

the limited time available for one-to-one care. Year of Care has provided a philosophy, structure and model, based on an extensive body of evidence which can address this.

Formal qualitative evaluation has demonstrated that the Year of Care approach is valued by both patients and clinicians, challenging previous approaches and clarifying expectations and roles. This is discussed in detail in a companion paper which can be found at www.practicaldiabetes.com.

Declaration of interests

There are no conflicts of interest declared.

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Year of Care: what do patients and clinicians think of this new approach?

Introduction

The importance of an 'agreed and shared care plan' was highlighted by the Diabetes National Service Framework.¹ Year of Care (YoC) set out to test whether the annual review could be transformed into a collaborative care planning consultation that would support self management (SSM).

The feasibility of delivering diabetes care in accordance with YoC Care Planning was tested across three pilot sites in England chosen for their areas of strength, expertise and demographics. The model and its delivery has been described elsewhere and is beyond the remit of this paper.²⁻⁴

During this pilot phase a local evaluation was conducted with patients and healthcare professionals (HCPs) to explore the experiences of those involved in care planning using qualitative methodology.

Aims

These qualitative interviews were intended to complement the national evaluation. The aim was to explore the experiences, opportunities and obstacles during the shift from traditional care to YoC care planning (Figure 1).

Method

A qualitative approach was selected using thematic analysis.⁵ The validity was established by the material being independently themed by another team member.

Participants: A total of 19 participants: 14 people with diabetes (7 men, 7 women, all with type 2 diabetes) and 5 diabetes healthcare professionals (3 nurses, 1 GP, 1 dietitian).

Participants were recruited from six general practices, specifically approached as they were at different stages of implementing the YoC approach. An essential inclusion criterion was that the clinicians were delivering a YoC style consultation.



Figure 1. The Year of Care process

Procedure: An invitation letter was sent to each practice introducing the evaluation and was followed up with a telephone call to clarify any issues.

Individuals with diabetes were introduced to the project by the clinician when they attended for their Care Planning appointment. If they agreed, the interview took place immediately after their consultation. Clinicians were interviewed at the end of their diabetes clinic if possible or a later date as soon as practicable.

The topic list was derived from a literature review. The semi-structured interviews lasted approximately 30 minutes and were completed by an independent research assistant. All interviews were digitally recorded and transcribed.

Ethical conduct: The National Research Ethics Service (NRES) assisted in defining this work as service evaluation rather than research⁶ there-

fore a Research Ethics Committee review was not required. The project was approved by the local Research and Development department.

Consent and Confidentiality: All participants were provided with an information sheet and consent form and encouraged to ask questions before agreeing to participate. All interview recordings and transcripts were anonymised and stored securely.

Results: individuals with diabetes

The themes are presented in Table 1. Three dots in quotes indicate missing text.

A. The prepared patient

Having access to information (such as test results) is an important factor in enabling individuals to make personally relevant decisions.^{2,3}

Many participants described the positive impact of receiving their biomedical results in the post prior to the consultation. It gave them time to think about the results and consider questions they would like to ask.

Getting all the results does give you time to think and I was thinking of any problems I've got before I came. [PWD5]

I mean all the information is there for you, so, there's no surprises when you come... you know what you are going to be talking about, so, it worked really well. [PWD12]

However there was concern about the suitability of the approach for all, with one participant commenting that it may induce anxiety rather than reduce it:

...It may scare them off (having results first). Health is one of those things some people would rather not know. People react in very different ways. [PWD6]

A tool for preparation

As part of the information sharing process people also received a

A. The prepared patient	B. Facilitators of the care planning consultation	C. Patient reactions and reflections
Time to prepare	Resources and tools	Increased understanding and its personal meaning
A preparation aid	Positive attributes of the HCPI	Positive feelings and benefits
	Partnership working	Reflecting on past and present
	Time	Promoting ownership Acknowledging personal barriers

Table 1. Summary of major themes and sub-themes from interviews with people with diabetes

document containing prompts, designed to encourage consideration of any issues that may be affecting their diabetes.

That is a plus factor that you get your results the same time as the medical people, and then your questionnaire allows you to put a little mark, to pencil in what you want to ask. [PWD11]

The questionnaire part of the results letter was good as it helped you think of questions. [PWD2]

B. Facilitators of the care planning consultation

Participants described key facilitators that aided the success of the consultation (Table 1):

Resources and tools

Participants reported tools and resources that benefited the consultation, particularly those that led to increased transparency.

...because sometimes you can mention... something, and then they write it down in a totally different way than what it was said. So this way you can see what is being said and if I wanted to change anything that was written I could do that, whereas normally you couldn't do that. [PWD8]

Positive HCP behaviours

Positive behaviours by the HCP were communication style, being empathic, supportive and genuine.

The [HCP] is understanding. She knows my background medically and has known me a long time. [PWD6]

Partnership working

Participants expressed feeling they had more choice and involvement in their care and communication was more balanced.

Before, things seem to get forced on you... whereas this way I prefer to discuss it myself... there's more of a choice now, it's my choice rather than someone else's choice, that's why I like it. [PWD8]

The style was, err, less clinical and more, um, personal, and I liked that... we were both communicating, I was communicating my ideas, and what I thought, as well as what the expert was telling me, and we seemed to come together on that. [PWD10]

Time

Many commented on the longer perceived length of time for the consultation.

The [HCPI] seems to have more time to deal with you personally, it's more personal. [PWD2]

Absolutely, you feel more at ease and able to discuss things because you know [HCP] is not in a hurry to palm you off and see the next person. [PWD5]

C. Patient reactions and reflections

This theme encapsulates participants' reflections on their experiences of their consultations.

Increased understanding and its personal meaning

Participants felt their understanding had increased following their consultation.

I got more information out of it than I probably did previously. Even though they were probably giving us the information, they were giving us it in a different way. [PWD12]

Positive feelings and benefits

There was a sense of positivity about the new style of consultation.

I think you're on to a winner, I really do. That's how I feel... I can't see how anyone could object to it or ask for change on it. I think it's good. [PWD11]

I always felt before that when you went to see the [HCP] that they listened to what you were saying, but I never really felt as if I came away with any benefit from it, whereas I feel I have this time... [PWD12]

Reflecting on past and present consultations

Participants reflected on the differences between past and present consultations.

There was no difference in the staff, just a difference in the way things were presented. [PWD1]

Promoting ownership

Several comments suggested the new consultation style had encouraged ownership of their diabetes and stimulated an increased sense of personal responsibility for self management.

...I've got to make these decisions, I mean, if I want to live till I'm 85 I've got to make these decisions coz I will pop my socks soon if I don't (laughs). [PWD10]

...It's like a contract, and I've signed it... It feels more positive because of this. People have committed themselves on both sides. [PWD1]

Acknowledging personal barriers

Many described barriers that may hinder progress towards achieving their goals. Most related to seasonal, lifestyle, or physical factors:

...a lot will depend on how much pain I get from my knees. [PWD12]

...my work is deskbound mainly so I don't get a chance to exercise as much as I would like. [PWD6]

A. Barriers and challenges	B. The facilitative healthcare professional	C. Personal reflections on experiences	D. Other factors aiding the consultation
Organisational and practical	Skills	Professional confidence and competence	Prepared patient
A balancing act	Role	Concerns and uncertainties	
Changing consultation style		Recognising patient benefits	
Adjustment and culture change		The outcomes of experiential learning	

Table 2. Summary of major themes and sub-themes from interviews with HCPs

Results: HCPs

The emergent themes from the interviews with HCPs can be found in Table 2.

A. Barriers and challenges

This theme encapsulates the reported barriers or challenges to adopting this style of working.

Organisational and practical

Many challenges in setting up were described i.e. extra paperwork, time for the consultation, re-organisation of clinics and dealing with non-diabetes issues.

Sometimes time hasn't let us do things as specifically as we would have liked. Everyone has gone away with a plan of knowing what they want to work on but the actual specifics of goal setting haven't always been done every time. [HCP4]

Quite often patients bring up other things not to do with Diabetes but that they want to ask while they are here. Goal setting really is dependent on how the consultation goes and how much time is left... It's nice if we have time to do everything but it's not always practical. [HCP4]

A balancing act

A source of tension for HCPs was feeling that they hadn't covered all aspects of clinical care.

...you do feel as if you are kind of more friendly with the patients, you feel, you know, that the patient can approach you

with anything, more during this type of consult, but there again it's that feeling at the back, have you really covered everything, that, you feel ought to be covered for that patients clinical care... [HCP2]

Some expressed being torn between giving control to the patients, and the Quality and Outcomes Framework (QoF).

...I have some concerns about the kinds of demands we have because of QoF, to kind of hit targets...but fair enough, patient choice, they should be able to deal with what they want to deal with first. [HCP2]

This highlights the tension between professional responsibility and patient choice.⁷

Changing consultation style

A recurring theme was the consultation style. Some found it difficult to hand over control and choice and others highlighted difficulties applying partnership working with 'unmotivated' individuals.

...at the outset I found it slightly difficult, kind of trying to be led more by the patient and it was an actual inclination to want to lead them just kind of the way as we've always done things... [HCP2]

A challenge for some was implementation of the 'micro-skills'. Several described feeling they lacked the specific skills and confidence.

The main thing I'm finding difficult is specific target setting with patients. It's hard to pin them down to a definite decision to what they will do and how they will do it. [HCP4]

Adjustment and culture change

HCPs signalled a period of adjustment when adopting the new style.

I'm finding it easier now I've done two or three clinics. It was strange at first getting into a new way of working. I thought I would never get used to it but it has got easier. [HCP4]

B. The facilitative healthcare professional

HCPs identified aspects of their behaviour that facilitated the process.

Skills

Specific skills were applied in consultations to enhance self-efficacy.⁸

...they tell me what they want to do, and I give them the opportunity to make suggestions about things they may change. I can then prompt them a bit to think about things that may help and try to narrow them down to a specific thing they are going to do and write it on their care plan or action plan... [HCP4]

Role

HCPs described their role as a facilitator, collaborator and information source.

I'm just the little pot of information they can dip into and take away what they want from it, and if I don't know, I will find out from somebody else and tell patients the answer. [HCP3/5]

C. Reflections on the journey to a new way of working

This theme captures HCPs experiences towards a new way of working.

Developing competence and confidence

Many described increased competency and confidence as they gained more experience.

It is more positive now. At the beginning I felt a bit overwhelmed by the thought that we had to change the whole way of working but once you get down to it, it becomes second nature. [HCP4]

Recognising patient benefits

All HCPs recognised the benefits to patients. Having an increased understanding of the patients' wants, needs and feelings also influenced their sense of fulfilment:

...Absolutely 100% better than it was, for me and for the patients. I mean that's what I am there for; I'm there for the patients and I feel that's what I'm giving them now. [HCP3]

I'm... actually feeling fulfilled, because... I feel as if they are talking about what they want to talk about. [HCP2]

Concerns and uncertainties

HCPs also expressed some reservations about the new style in terms of its direct impact on them and sustainability.

I was also worried about the secretaries having to do an extra letter. I had concerns about the time element, postage costs etc, but overall the benefits outweigh the negative side. [HCP4]

The outcomes of experiential learning

During the transition phase HCPs revealed a number of learning outcomes:

...with a lot of the patients, um, you're speaking more on a one to one... I find a lot of the patients seem to be talking and expressing their feelings more than they used to... that's very encouraging... [HCP2]

D. Other factors aiding the consultation

Other helpful aspects of the YoC model were highlighted.

Prepared patient

HCPs described how receiving results in advance facilitated the consultation by preparing the patient and enabled them to feel more at ease:

...some people have come in quite actively engaged with it... and some people are actually raising issues, err, triggering questioning...so that as a tool in itself is quite useful and often a good basis to start the conversation off. [HCP1]

Overall it has worked well. People felt more comfortable and it has given them the

chance to see what is what beforehand and then we can spend more time in the consultation actually deciding how to improve things or what they want to do next. [HCP4]

Discussion

This small service evaluation indicates this approach allowed people with diabetes to prepare for their consultation through receiving their results and written prompts in the post in advance. This additional preparation time provided an opportunity to think about their results, barriers to self management, and created a more equitable relationship with their HCP.

Participant responses indicated improved partnership working where they felt their agenda, thoughts and feelings were more considered. The communication was more balanced and they had greater choice and control. There was also an appreciation of the time given to set agendas and explore and discuss issues, contributing to a sense of a more 'personal' consultation. Certain behaviours demonstrated by the HCP were considered to be important for the success of the consultation and concurred with the humanistic principles of genuineness and empathic understanding which are well known to be effective facilitators of a therapeutic relationship.⁹

Participants reported leaving the consultation feeling more informed about their diabetes, how it relates to them personally, its management and expressed an explicit preference for the new style. Having their results, prompt questions and an action plan was considered beneficial. A further effect was a self-reported increase in motivation, confidence and self-efficacy encouraged by the perceived increased level of support from the HCP. For some, there was a recognition that joint commitment from both individuals helped to increase levels of personal responsibility self management.

Overall, service users were positive and welcomed the new style. The results support the development of increased patient understanding, support and autonomy. These have been linked to improved outcomes, self directed behaviour changes, and

increased self management.^{10,11}

HCPs also recognised the benefits of this approach both for themselves and patients. The HCP experience was reported by some as more fulfilling, and having a 'prepared patient' was seen as positive and facilitated the consultation.

Nevertheless, HCPs experienced barriers and challenges. This is perhaps to be expected given the organisational changes required to implement YoC. A period of adjustment was described during transition and that over time the application of the new style became easier.

Tensions arose over the balance between perceived professional responsibility and patient choice.⁷ Again, this appeared to diminish as HCPs became more comfortable with the changing dynamics in the relationship, and the benefits of the patient to having a more active role. HCPs identified struggles with those who appeared 'unmotivated' and highlighting the importance of skills around behaviour change and motivation.¹²

For the future

The YoC model^{2,3,4} emphasises the role of the 'HCP committed to partnership working', an 'engaged, informed patient' and commissioning and organisational processes to ensure effective care planning. Given this model, and taking into account the results reported in this evaluation, a number of recommendations are possible.

- Embedding the approach takes time and requires significant partnership working between commissioners, senior managers and clinicians.
- Patients may need further education and training to help make use of the approach and may desire opportunities to learn about care planning through various formats (for example, media, e-learning, patient forums, information leaflets, DVDs).
- The skills and organisational structures required for this approach are applicable to the management of other long term conditions.
- Clinicians should be supported to access a programme of continuing professional development particularly focussing on how to work with

individuals who they would describe as 'unmotivated'.

For some the shift from a clinician led consultation to one of partnership working requires significant change in culture as well as processes.

Limitations

Participants interviewed were a self-selecting sample although the Practices invited to take part were chosen for being at different points in the journey of implementing YoC. It was reported that all participants had completed a care planning consultation but this was not measured objectively. The sample was also restricted to a relatively small urban area with a majority white population.

Private space for conducting the interviews was an issue in some GP surgeries and in some cases this restricted the participation of those

who were initially keen to take part.

Next steps

Although this evaluation provides valuable positive feedback and some challenges in adopting this approach, further evaluation is required. The needs of 'hard to reach' groups have not been explored and are being investigated by other pilot sites.

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