



# How much do clinicians support patient activation?

A survey of clinician attitudes and behaviours towards people taking an active role in their health and care

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## Acknowledgements

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We would like to thank Professor Judith Hibbard and Dr Alf Collins, the creators of the original survey and the Clinician Support for Patient Activation Measure, for their guidance in the further development of the survey to understand clinician attitudes and behaviours.

Special thanks are due to Insignia Health for allowing us the use of their survey and for all their hard work in the analysis of the clinician responses.

We are very grateful for the ongoing support and help from all our colleagues in NHS England, including the Domain 2 team, Nursing Directorate, Insight team, Analytical team, Communications team and the Publishing team to name but a few.

We further look forward to working with our stakeholder organisations - professional bodies, patient representative groups, system leaders and national and local decision makers - to address the findings from the survey.

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## 1 Executive summary

People manage their health and care on their own, or with support of their family and carers, the vast majority of the time. Understanding this role and developing their knowledge, skills and confidence to take it on is key, and this can have positive impact on health and social outcomes, personal experience and appropriate use of services. Patient activation is described as the knowledge, skills and confidence people have to manage their own health and care and this can be quantified using the Patient Activation Measure (PAM)<sup>1</sup>.

The NHS Five Year Forward View acknowledges the need to support people to manage their health and care. It makes a commitment to investment in evidence-based approaches that build people's confidence and skills, such as group based self-management education courses for people with specific conditions, as well as encouraging independent peer-to-peer communities to emerge. Such approaches support the promotion of equality and the reduction of health inequalities in the population.

Clinicians also have a key role to play in patient activation. However, a 2009 survey of 175 primary care clinicians in the US and UK (including 77 in the UK) indicates that they are variable in their levels of support<sup>2</sup>. This was assessed using a tool known as the Clinician Support for Patient Activation Measure (CSPAM).

This piece of work aims to build on these findings. It uses the CSPAM to explore current attitudes and beliefs of 1759 clinicians (including 778 doctors, 595 nurses and 386 allied health professionals). The survey also looks at clinicians' self-reported behaviours and practices, and provides insight into their perceived barriers and support needs.

### 1.1 Key findings

#### 1.1.1 How much do clinicians support patient activation?

- This survey shows that clinicians vary significantly in their support for patient activation. A wide range of CSPAM scores were seen across the sample (36.4 to 100), demonstrating that some clinicians are more supportive of people taking an active role in their health and care, while others are less so. These findings are similar to those of the 2009 study, indicating that clinician attitudes have not shifted very much in the last five years.
- Clinician support for patient activation is not significantly affected by age, gender and region. However, clinician role does seem to have an impact, with nurses having the highest average CSPAM score (75.9) compared to doctors (70.1) and

<sup>1</sup> Hibbard JH, Stockard J et al. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers. *Health Services Research*. 2004; 39(4 Pt 1): 1005–1026.

<sup>2</sup> Hibbard JH, Collins PA et al. The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*. 2009; 13: 65-72.

allied health professionals (AHPs 71.7). Taken together, these factors only account for 4 percent of the overall variation.

- Clinicians are most likely to support those aspects of self-management that relate to a patient making behaviour and lifestyle changes in accordance with clinical advice. They are less likely to support people making independent judgements and taking independent actions when caring for themselves at home, or people functioning as a member of the care team. They are least likely to support people being independent seekers of information. These findings are also consistent with the 2009 study<sup>3</sup>.

### **1.1.2 What do clinicians say they do in practice?**

- The survey also indicates that clinicians vary significantly in terms of their behaviours and practices towards supporting self-management by people (overall behaviour scores range from 25 to 100). There is a strong correlation between CSPAM scores and self-reported behaviours, indicating that clinicians that support patient activation are more likely to engage in partnership building behaviours with people.
- Among the behaviours studied in the survey, clinicians said that they were most likely to alter their approach according to a person's level of skills, knowledge and confidence. On the other hand, they were least likely to ask people what changes they wanted to focus on.

### **1.1.3 Perceived barriers and support needs**

- Many of the perceived barriers reported by clinicians were system based and related to people, and some related to clinicians themselves. These included: time constraints during consultations, insufficient resources and support services, unhelpful pathways and processes; people having limited ability or willingness to take a more active role in their care; and clinicians' own skills and levels of understanding.
- A range of support needs were also identified. To overcome some of the system barriers, clinicians suggested improved service design with longer appointments for people with greater need, and availability of more local services to support people. They also felt that many people would benefit from support and education, which would empower them to take a more active role in the management of their health and care. Some clinicians also suggested that training, such as in motivational interviewing techniques and communication skills would help them give more support to people.

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<sup>3</sup> Hibbard JH, Collins PA et al. The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*. 2009; 13: 65-72.



## 1.2 Summary of implications

This report gives a snapshot of current clinician attitudes and behaviours towards patient activation and it identifies a range of perceived barriers and support needs. The comments made by clinicians in the survey show that many believe it is important to address elements across three key areas in the healthcare system to enable the delivery of person-centred care. This includes

- better support for clinicians;
- targeted support for system change; and
- support for individuals to engage in their health and care.

### 1.2.1 Support for clinicians

The survey shows that clinicians are variable in their support for patient activation; some identified development or training needs which could support them to help individuals to take a more active role in their health and care.

- The findings will support Health Education England (HEE) in their consideration of training and support for person-centred care, and assist in the development of design principles to support workforce planning, education and training programmes.
- The Royal College of General Practitioners (RCGP) will address the communication skills needs of clinicians in training, guidance and online tools developed through their Collaborative Care and Support Planning programme.
- The Nursing division at NHS England will use the findings in their Behaviour Change and Nursing Strategy, and will work with HEE to include patient activation and behaviour change in their education specification.
- The Realising the Value Programme, funded by NHS England, will use behavioural insights to support clinicians, individuals, communities, providers and commissioners to bring about the culture change that is needed in this area.

### 1.2.2 Support for system change

The findings show that clinicians feel that more needs to be done to enable systems and processes to support them to deliver person-centred care.

- NHS England will use the findings to consider system levers and barriers for supporting person and community centred approaches to care through the Realising the Value programme.
- NHS England will also consider opportunities arising through the New Models of Care and Integrated Personal Commissioning programmes to explore different approaches to redesign.

- The Coalition for Collaborative Care (C4CC) will continue to take action to support local change, and create the conditions nationally through system and financial levers to remove barriers and incentivise the changes needed to enable clinicians to work in a person-centred way.
- The Royal College of General Practitioners (RCGP) has indicated that the appetite for longer appointments for GPs is encouraging for their Collaborative Care and Support Planning programme, and they will aim to work out ways to help practices and Clinical Commissioning Groups (CCGs) free up GPs' time to deliver this.

### 1.2.3 Support for individuals

Clinicians offered an insight from their experience into the perceived needs of people to support self-management of their health and care.

- NHS England will continue to work with national organisations to improve the quality and accessibility of patient information through The Information Standard and the Accessible Information Standard. NHS England is also initiating cross-cutting work to consider what support can be made available to increase health literacy.
- To increase access to support for self-management and community centred approaches, the Realising the Value programme will aim to identify evidence based approaches and develop tools to support implementation across the NHS and local communities.
- The Coalition for Collaborative Care will work with professional champions, experts and leaders, and people with long-term conditions to help communities with practical support including providing information and networking groups for support, learning and training.

## 1.3 Conclusion and next steps

The findings give a snapshot of current attitudes across the clinicians surveyed, and provide us with insight that will be built upon in working with clinicians on their support for patient activation. We welcome the positive finding that many clinicians are broadly supportive of patient activation, although there are still a range of attitudes identified. The findings of the survey also point to the fact that while all clinicians have their own individual attitudes towards patient activation, they also report significant structural barriers which can sometimes prevent them from being able to practice in a person-centred way.

NHS England will work with key stakeholders - professional bodies, patient representative groups, system leaders, national and local decision makers - to start reflective conversations, to identify how it can work in partnership to address the issues identified in the survey. The findings in this report will support the Royal Colleges and Health Education England in their consideration of training and support

for person-centred care, and will assist in the development of design principles to support workforce planning, education and training programmes. The findings will also support NHS England in its work to support the aspiration of the Five Year Forward View to create a health and care service that focuses on the needs and assets of individuals.

Finally, organisations and clinicians can use the survey as a tool to reflect on their attitudes and practices towards supporting people in taking a more active role in their health and care.

## 2 Introduction and rationale

People manage their health and care on their own, or with support of their family and carers, the vast majority of the time. Having the knowledge, skills and confidence to do so is key, and this has a positive impact on health and social outcomes, personal experience and appropriate use of services. Patient activation is defined as the knowledge, skills and confidence people have to manage their own health and care - this can be quantified using the Patient Activation Measure<sup>4</sup>. People can be supported to develop these skills through targeted interventions such as peer support and health coaching to enable them to have a more active role in their health and care<sup>5</sup>.

The NHS Five Year Forward View acknowledges the need to support people to manage their health and care. It makes a commitment to investment in evidence-based approaches that build people's confidence and skills, such as group based self-management education courses for people with specific conditions, as well as encouraging independent peer-to-peer communities to emerge. Such approaches support the promotion of equality and the reduction of health inequalities in the population.

Clinicians also have a key role to play in patient activation. However, a 2009 survey of 175 primary care clinicians in the US and UK (including seventy-seven in the UK) indicates that they are variable in their levels of support<sup>6</sup>. This was assessed using a tool known as the Clinician Support for Patient Activation Measure (CSPAM). The survey found that clinicians strongly supported people following medical advice; and were less likely to support people making independent judgements and actions and people functioning as a member of the care team. Clinicians were least likely to support people being independent information seekers<sup>6</sup>. All of these competencies are important for people to successfully self-manage their health and care.

This piece of work aims to build on these findings. It uses the CSPAM to explore current attitudes and beliefs of a range of clinicians, including doctors, nurses and allied health professionals. The survey also looks at clinicians' self-reported behaviours and practices, and provides insight into their perceived barriers and support needs.

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<sup>4</sup> A tool, known as the Patient Activation Measure (PAM), has been developed to help assess a patient's knowledge, skills and confidence in self-management. More details about the measure are included in Appendix A1.

<sup>5</sup> The Kings Fund. Supporting people to manage their health: An introduction to patient activation. Hibbard and Gilbert, May 2014.

<sup>6</sup> Hibbard JH, Collins PA et al. The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*. 2009; 13: 65-72.

### 3 Methodology

A web-based survey was conducted by NHS England in November-December 2014. The survey was disseminated with the support of four of the Royal Colleges and other partners through available online channels<sup>7</sup>.

The survey included 14 questions from the original Clinician Support for Patient Activation Measure (CSPAM) tool, developed by Judith Hibbard, and validated through the study of 175 clinicians<sup>8</sup>. Clinician support for patient activation has been assessed according to the original methodology used in this earlier study, and is described as a “CSPAM score”, created using Rasch analysis of the 14 CSPAM items (described in Appendix A2).

An extra set of questions to assess clinician behaviours were also developed and included as part of this survey (Appendix B). Additionally, free text fields were provided to gain more in depth, qualitative insight into clinicians’ views, approaches used by them and their support needs.

The data has been analysed by Insignia Health with support from NHS England. Tests of significance such as analysis of variance and Pearson chi square tests were performed on the quantitative data as appropriate. For the qualitative analysis, themes were identified manually from the free text responses and organised into coherent categories. The categories that emerged more frequently were analysed and included in this report.

#### Limitations

As the respondents were a self-selected population, sampling bias in the results cannot be ruled out. If there is a skew, it is likely towards people more interested in person-centred care. The clinicians’ attitudes and behaviours are self-reported, so may not measure what their behaviours actually are or how people understand them to behave. It is possible that there may be under/over-reporting by the whole or parts of the group. For all of these reasons, the scores of the respondents in the survey may not be representative of the general clinician population.

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<sup>7</sup> Royal College of Physicians, Royal College of GPs, Royal College of Nursing, Royal College of Psychiatrists, Allied Health Professions Federation, doctors.net, National Clinical Directors and colleagues in NHS England.

<sup>8</sup> Hibbard JH, Collins PA et al. The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*. 2009; 13: 65-72.

## 4 Findings from the survey

### 4.1 Distribution and demographics of survey respondents

The distribution of the survey respondents is given in the table in Appendix C. The demographics of the study population was found to be broadly consistent with the general clinician population – with some under-representation of younger clinicians. There was a low representation of minority ethnic groups among the respondents. Some regions were more represented than others in the sample (Table 3, Appendix C).

A total of 1759 clinicians participated in the survey – these included 778 doctors, 595 nurses and 386 allied health professionals (AHPs) in England.

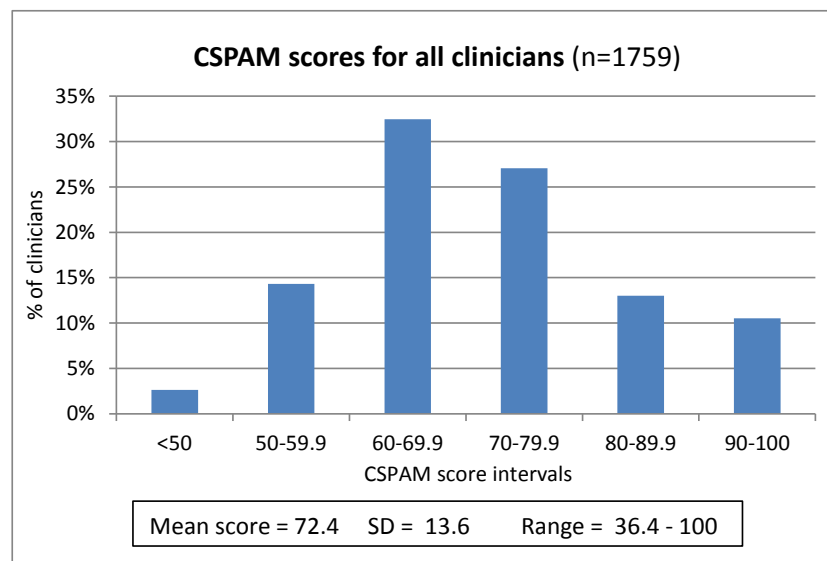
- Among the doctor respondents, there were 247 GPs, 400 consultants and 83 doctors in training. Major specialties included renal medicine, palliative care and mental health.
- Nurse respondents worked in the areas of primary care, community nursing and secondary care such as palliative medicine, renal, cardiology and neurology.
- AHP respondents worked in the areas such as orthoptics, emergency care, palliative care, ophthalmology and mental health.
- Overall, 88 percent of the survey respondents primarily provided care to people with long term conditions. The data was analysed separately for this group, and as no significant variation in results was seen between this group and others who provided care more generally, all the respondents were included in the analysis (Table 4, Appendix C).

### 4.2 Clinician support for patient activation (CSPAM)

The Clinician Support for Patient Activation Measure (CSPAM) assesses how far clinicians value people's role in the care process. The CSPAM score indicates an individual clinician's overall level of endorsement or belief about the importance of patient activation. A score of 100 indicates that the clinician self-reports that they are fully supportive, whereas a lower score indicates lesser support for patient activation.

The study found a wide variation in clinicians' support for patient activation with a range of scores seen across the sample (Figure 1) – from 36.4 to 100. The mean CSPAM score for all clinicians was 72.4.

Figure 1: CSPAM scores in study



#### 4.2.1 How much do demographics and role affect CSPAM scores?

- Within the three cohorts (doctors, nurses and AHPs), no significant variation was seen in CSPAM scores by age, gender or region (refer to Table 5 in Appendix D1 for statistical values).
- There was a small but significant variation seen in CSPAM scores by clinician role – on average, nurses had a higher CSPAM score (75.9) compared to doctors (70.1) and AHPs (71.7) ( $F=31.98$ ,  $p<0.00001$ ; also refer to Figure 4 in Appendix D1).
- The doctors' scores in this survey were similar to those of 77 UK primary care clinicians (69) in the 2009 study<sup>9</sup>.
- There was no difference in the CSPAM scores for GPs (70.3) compared with other doctors (70.0) ( $F<1$ ).
- Consultants had a statistically significantly higher CSPAM score (70.9) compared to doctors in training (66.3) ( $F=3.95$ ,  $p=0.008$ ).
- Demographic variables (age, gender and region) along with clinician role, accounted for a small proportion (4 percent) of the difference in scores. These demographic variables, by themselves, only accounted for less than 2 percent variation in the scores.

#### 4.2.2 Which patient competencies do clinicians support more easily than others?

As per the methodology used by the developers of the original CSPAM survey, Rasch analysis was used to calibrate the 'difficulty' of the 14 items that make up the overall CSPAM (Appendix A2). The items in the survey which clinicians most often

<sup>9</sup> Hibbard JH, Collins PA et al. The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*. 2009; 13: 65-72.

agreed with received a low difficulty score, whereas items which fewer clinicians agreed with received a greater 'difficulty score'.

Based on the difficulty scores, the original survey grouped the items into four sets of skills/competencies that are considered important for people to take an active role in their health and care. The difficulty scores of this study for all clinicians are shown in Table 1 below and by clinical roles in Table 6, Appendix D2. The items in the survey covered a range from 33 to 70.

Table 1: Patient competencies and difficulty structure for all clinicians

As a clinician, how important is it to you that your patients:	All clinicians
<b>Manage behaviours &amp; lifestyles and follow clinical advice</b>	
1. Are able to take actions that will help prevent or minimise symptoms associated with their health condition(s).	37
2. Are able to make and maintain lifestyle changes needed to manage their long term condition.	43
3. Understand which of their behaviours make their long term condition better and which ones make it worse.	36
4. Can follow through on treatments you have told them they need to do at home.	50
<b>Can make independent judgement and actions</b>	
5. Know what each of their prescribed medications is for.	47
6. Believe that when all is said and done, they are the ones responsible for managing their health.	55
7. Are able to determine when they need to go to a medical professional for care and when they can manage the problem on their own.	49
8. Are able to work out solutions when new situations or problems arise with their health condition(s).	49
<b>Able to function as member of the care team</b>	
9. Want to be involved as a full partner with you in making decisions about their care.	52
10. Tell you the concerns they have about their health even when you do not ask.	44
11. Want to know what procedures or treatments they will receive and why before the treatments or procedures are performed.	52
12. Understand the different treatment options available for their long term conditions.	49
<b>Is an independent information seeker</b>	
13. Look for trustworthy sources of information about their health and health choices, such as on the web, news stories or books.	61
14. Bring a list of questions (on paper or otherwise) when they come to the clinic.	65

Difficulty structure: Easiest shaded blue; hardest shaded pink

The difficulty structure gives some insight into clinicians' varying support for the different items. It shows that of these four sets of competencies, clinicians are more likely to support statements that relate to people managing their behaviours and lifestyle, and following clinical advice. The clinicians in our survey were less likely to support people making independent judgements and actions, and people functioning as a member of the care team. The final two items in the survey were related to



people seeking information independently to manage their own health and care, and were least likely to be endorsed by clinicians.

#### 4.2.3 Qualitative insight into clinicians' support for patient activation

The qualitative material from clinicians' comments in the survey provides an insight into the reasons for clinicians' varying support for different aspects of patient activation:

- The item on patients 'bringing a list of questions when they come to the clinic' got the least support from clinicians. Some clinicians welcomed people bringing a list of questions to the clinic and felt it should be actively encouraged as it helped people to organise their thoughts and brought focus to the consultations. However, others said that while lists could be useful, they could sometimes distract from the clinical issues. Many clinicians, especially GPs, felt that the time available during consultation was a significant issue and there was a need to be careful with a list of questions as it could take up too much time. They also gave suggestions that what people discuss with different staff, such as doctor, nurse or receptionist, could be prioritised.

"The lists can be a help or a burden - sadly the longer the list the less useful it is and can cause the clinician to miss the wood for the trees." GP

"In an ideal world where we have all the time in the world, yes that is helpful. In the reality of the doctor's surgery, lists can make consultations fail due to unrealistic expectations." GP

- The item on patients 'looking for trustworthy sources of information about their health and health choices' also got relatively little support. Many clinicians thought it was important for people to be empowered through information about their health condition, but there was concern among some clinicians about the availability of trustworthy sources of information to people, especially on the internet and news stories, and some expressed the need for more reliable information.

"Information available on the internet can be confusing and often incorrect and is not individualised - patients often come to clinic with information they have gleaned from elsewhere and have managed to make themselves very anxious." Nurse

- Many clinicians, especially nurses and allied health professionals, found it difficult to support the statement that patients 'believe when all is said and done, they are responsible for managing their health'. They felt that it was important to balance care with the patient's preferences and their level of knowledge, skills and confidence. Some clinicians felt that some people needed greater support than others and that it should be a shared responsibility between the clinician and the patient. Some felt that being 'engaged' was not the default position for all people,

especially those with limited capacity due to their health condition. GPs found it easier to support this item compared to other doctors.

“Not everyone is aware of their responsibility or has the capacity to understand, so the management of conditions should be shared if the patient wishes - with them having partnership in decisions and care.” Primary care nurse

- Clinicians, especially doctors, found it difficult to endorse the items on ‘patients wanting to be involved as full partners in making decisions about their care’ and patients ‘wanting to know about procedures/ treatments they will receive and why, before the treatments were performed’. GPs found the latter statement more difficult to endorse than other doctors. Several clinicians said that care should be individualised to people’s abilities, and it was important to work with the individual at their pace.

“We must not impose involvement on patients who do not want to take this responsibility or do not have the resources to take more control. Our actions as clinicians should be to increase the resources available for patients to take up as they are willing and able to do so. It is authoritarian to impose our view of the ideal patient.” GP

- The item on patients following through on treatments they have been told to do at home got relatively less support from clinicians. Many clinicians said that they should not be ‘telling’ them, it should be a shared decision between the clinician and the patient.

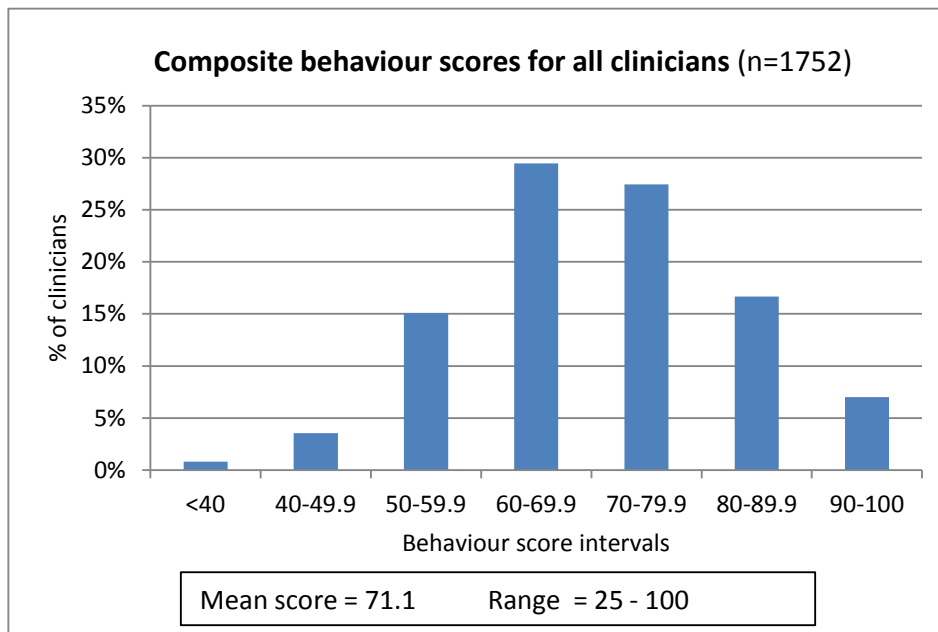
“Surely we should not be ‘telling patients what they need to do themselves at home’ - clinicians should be giving information, discussing options, negotiating action plans - NOT ‘telling’.” GP

### 4.3 Clinicians’ behaviours to support patient activation

The survey included a series of questions about clinicians’ behaviours related to supporting patient activation and partnership building with people with long term conditions (Appendix B).

Responses to nine ‘behaviour’ questions were combined to create a composite ‘behaviour’ score for each respondent which reflected their self-reported rate of engagement in activities which build partnership with people and support patient activation. The range in scores seen across the sample (25-100) indicates significant variation in partnership building activities across clinicians (Figure 2). The mean score for all clinicians in the study was 71.1.

Figure 2: Composite behaviour scores of clinicians



The study found a strong correlation between CSPAM scores and self-reported behaviours. Clinicians with higher CSPAM scores were more likely to report undertaking partnership building behaviours more frequently (Appendix D3).

#### 4.3.1 How much does role affect reported behaviours?

Scores differed significantly by the role of the clinician, with nurses having the highest scores. They were significantly more likely than doctors and AHPs to say that they engaged in patient-centred behaviours (Appendix D4).

- Nurses had the highest composite behaviour score of 75.9, significantly higher than doctors and AHPs ( $F=6.93$ ,  $p=0.009$ ). They had the highest response rate of 'always' to the behaviour questions.
- AHPs had the composite behaviour score of 73.1, significantly higher than doctors.
- Doctors had a mean composite behaviour score of 66.4 (GPs had a slightly lower mean score of 65).

#### 4.3.2 Which partnership building activities were clinicians most likely to undertake?

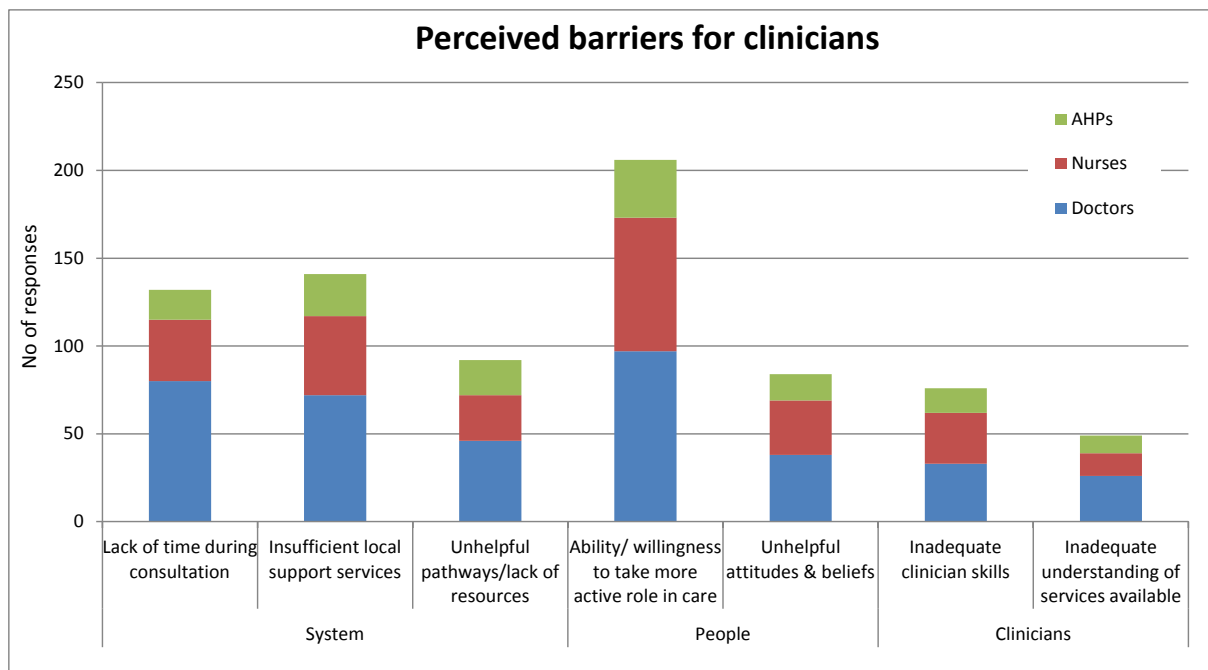
Among the behaviours studied, clinicians reported that they were most likely to alter their approach according to the patient's level of knowledge, skills and confidence to manage their health – 80 percent of nurses, 68 percent of AHPs and 57 percent of doctors reported that they 'always' altered their approach. On the other hand, they were least likely to 'always' ask patients what changes they wanted to focus on (Appendix D4).

The next section provides an insight into some of their reported reasons for these behaviours, or the variations between the different groups, using qualitative material from clinicians' comments.

### 4.3.3 Qualitative insight: barriers and support needs reported by clinicians

Open ended responses received from over 700 respondents provided very rich insight into some of the barriers clinicians said they faced (Figure 3) and their support needs (Table 2). Clinicians gave examples of approaches they used for providing person-centred care - some of these are summarised in the section below.

Figure 3: Perceived barriers for clinicians



- **Time constraints during consultation**

A very significant barrier identified towards providing more personalised care was the availability of time during consultation. This was raised by a large number of clinicians, including over 40 GPs who said that they did not have enough time to discuss patient goals and write action plans in their 10 minute appointment because of the need to focus on the medical aspects of the problems. Some signposted their patients to the nurse who they believed had more time.

“I have 10 minutes to spend with patients which barely touches the surface - you could easily spend an hour talking through these things and still the patient may not be able to understand.” GP

A rheumatology consultant said that although she had tried identifying personal goals and developing action plans earlier, she found it difficult due to

lack of experience and time in the standard clinic setting, and now did it outside the clinic.

“There just isn't the time. We have therefore developed a Living Well with Arthritis course where small groups meet weekly for 3 hours for 7 weeks and there is time for goal setting and review during that.”

Other clinicians also highlighted the problem of time available during consultation.

“This is really hard to do all the time with increasing time pressures - it is absolutely how we need to be moving our practice forward, but the gap between 'should' and 'can' is difficult to negotiate in the present climate (an observation, not an excuse).” AHP

Some clinicians, GPs in particular, suggested longer half hour appointments for people with complex medical problems to make each appointment more productive, even as others felt that they were already overstretched and lacked the capacity to offer these.

- **Insufficient resources and support services**

Many clinicians felt that they were under-staffed and under-resourced and were struggling to cope with their current workload. An AHP said that their communication with people got affected when they were tired after 12 hour working days. Some clinicians believed that the system did not encourage personalised care, and while some aspirations were good, they did not feel supported.

“We are trying to increase the number of patients who participate in self-care. We have been remiss in this area, units were chronically poorly ‘minimally’ staffed, but staff are encouraged to recognise long term gains to both patients and staff which arise from patients becoming more involved.”  
Renal nurse

A number of clinicians raised concerns over the provision of support services locally, such as those providing social and psychological support. Where services were available, they were often described as limited or stretched with long waiting times.

“I manage a physiotherapy service for people with long term neurological conditions, and other services frequently signpost to us. However we are hugely under resourced and therefore unable to meet patients’ expectations. I wish CCGs would stop commissioning new signposting services and invest in core services first.” AHP

Some clinicians suggested having a single coordinated approach to care for people with long term conditions where patients, carers and healthcare professionals could ring for advice and support and signposting to local resources.

- **Unhelpful pathways and processes**

A number of clinicians said that person-centred care was very important but the current pathways and processes within the NHS were not very helpful, and a change in pathways was needed.

“NHS hospitals are not geared up to offer flexibility in terms of care. If patients do not fit into the standard model of treatment and follow up, it causes problems as systems are rigid and inflexible.” Doctor in training

Many clinicians said that though it was not suitable, they ended up suggesting multiple changes in a single consultation due to pathway constraints or patient condition/circumstances. Clinicians said improved pathways would allow more continuity of care, and better access to expert advice for people in times of need would help to improve patient confidence. Some clinicians also suggested that shared IT systems and greater use of technology would help them to share information between services and with people more easily.

Some GPs said that the Quality and Outcomes Framework and the target culture got in the way of doing things the way they would like. Others found it difficult to keep up with changes in guidance, targets and treatments.

- **Ability/willingness of people to take a more active role in their care**

Several comments from clinicians reflected the need to balance care according to their needs. A large number of clinicians said that limited capacity or understanding in many people affected their ability or willingness to take a more active role in their care.

“To bring about behaviour change involves a long process of promoting knowledge and often a change in attitudes. Taking responsibility for one’s own health is not always a given.” GP

Some clinicians felt that education, peer support and health coaching for patients and carers would help to empower them.

“It is part of our role to work with patients and identify goals, breaking them down into achievable steps/tasks for them.” Occupational Therapist

Some clinicians highlighted the role of the voluntary and community sector in supporting people and giving them the confidence to discuss their needs before their condition worsened.

- **Unhelpful attitudes and beliefs of people**

Some clinicians said that at times, people were in denial about their own lifestyle choices (such as inactivity, smoking, drugs and alcohol) and the direct effect it had on their health. A few GPs said that some of these people were not always completely honest with their clinicians. Patients and their families would benefit from counselling in the early stages of the diagnosis of their LTC, so that they were in the best mental state to deal with these conversations and complications. They needed support to implement things that helped such as taking medication regularly, seeking help, or avoiding things that exacerbated their health problems in the longer term.

“The dilemma comes when people seem oblivious to the harm that they cause themselves. I avoid to 'do what is in their best interests' as that appears medically paternalistic.” GP

Several clinicians said that there was a need to change the culture of ‘clinician knows best’ in some people. It was important to help people understand that encouraging them to self-care did not mean that they were being abandoned by the health services.

“Many patients have got used to thinking that every problem with their health has to be dealt with by a doctor. We need to educate them that there are often other strategies that are not dependent on seeing a doctor that are usually as good, if not better and quicker.” Doctor

- **Clinician skills and understanding**

About 80 clinicians commented that their skills could be improved; some commented that training in skills such as motivational interviewing and health coaching would be useful, particularly at the beginning of their careers.

“I feel that we are not given enough tools or skills to manage self-management. A basic change in approach in training is required - motivational techniques and communication skills training would all be useful.” Nurse

A renal consultant found motivational interviewing training by a psychologist on consultation styles, of great value for their unit. For some clinicians, training

about different learning styles had significantly improved staff-patient relationships. Several clinicians felt that they lacked adequate training to assess and adapt to individual patient activation levels, and multi-disciplinary teams could help them to provide a better service.

Some clinicians felt that the importance of patient activation was not fully appreciated by clinicians, and that a culture change was needed.

“A large part of the issue with supported self-management and other models that shift the balance of power and responsibility away from the health professional is that we are trying to do this with staff trained to deliver hands on care and who can be task driven.” AHP

- **Understanding and use of available services and resources**

Several clinicians expressed a lack of knowledge of available services and resources, and how to signpost to them.

“Very deficient in psychological support in house or understanding complexities of signposting. I don't even know what is available or how to find out, and in general have to refer back to GP.” Renal doctor

A number of clinicians suggested there was a need for a comprehensive web-based list or directory of local services:

“The lack of time to learn about the third sectors available for particular LTCs - often we are ignorant of what is out there. Numerous emails telling us of services available just get lost in the huge number of emails received each day. A central website for signposting all these services would be helpful - it needs to be localised as services differ so much between areas [...and] regularly maintained.” GP

An AHP said that he had built a directory of services in partnership with voluntary organisations as they found it very hard to keep up to date with all the networks and services available.

Some clinicians said that they used the information resources available and found websites like NHS Choices and Information Prescriptions useful. A GP found the patient.co.uk leaflets useful for people with low literacy. Some web based tools and apps were being used. Some clinicians tailored information from local, regional and national sources to use throughout the pathway of care. Others in diabetes self-management had developed pre-consultation reflection sheets, automated health profiles and easy online printable care planning discussion sheets to support people.



Table 2: Summary of support needs identified by clinicians

System support	Support for people	Support for clinicians
<p>1. Improved service design</p> <ul style="list-style-type: none"> <li>▪ Longer appointments for people with greater need</li> <li>▪ Increased MDT type of working to address patient needs including psychological support</li> <li>▪ More support services available at a local level</li> <li>▪ Improved pathways to include more continuity of care</li> </ul> <p>2. Better access to expert advice for people when needed</p> <p>3. Shared IT systems to enable better information sharing between services</p> <p>4. More tools and resources</p> <ul style="list-style-type: none"> <li>▪ Improved goal setting and personalised care planning, self-management plans for people</li> <li>▪ Reliable information resources</li> <li>▪ Greater use of technology to support clinicians and people</li> </ul>	<p>5. Support and education to help empower patients and carers in relation to their health and change attitudes of 'clinician knows best'</p> <p>6. Increase in support services such as peer support, patient groups, voluntary and community sector and community support</p> <p>7. Better information support such as online and interactive resources, easy read leaflets</p>	<p>8. More staff training to develop their</p> <ul style="list-style-type: none"> <li>▪ communication skills and motivational interviewing techniques</li> <li>▪ recognition of patient's activation level and provide holistic support to people</li> </ul> <p>9. Culture change in clinicians to share power and responsibility with people</p> <p>10. Improved understanding about available services locally</p>

## 5 Discussion

### How much do clinicians support patient activation?

Patient activation describes the knowledge, skills and confidence that help people to manage their own health and care. Clinicians have an important role both in supporting people to self-manage their conditions, and also in helping to build their level of activation. Building confidence through positive experiences and encouraging small steps are key to increasing people's activation level. Clinicians need to take a more long-term, individual and somewhat different approach that includes a shift from simply delivering information to the patient so that they make behavioural improvements, to recognising what is involved for people to acquire self-management skills<sup>10</sup>.

This survey shows that clinicians vary significantly in their support for patient activation. A wide range of CSPAM scores were seen across the sample (36.4 to 100), demonstrating that some clinicians are more supportive of people taking an active role in their health and care, while others are less so. The results are similar to those of the previous 2009 survey, which suggests that clinician attitudes have not shifted very much with time.

The survey found that clinicians are most likely to support those aspects of self-management that relate to a patient making behaviour and lifestyle changes in accordance with clinical advice. They are less likely to support people making independent judgements and actions, and people functioning as a member of the care team. Clinicians are least likely to support people being independent seekers of information. These findings indicate that some clinicians still struggle to support those aspects of patient activation which involve people needing more independence and autonomy.

There were some differences seen in the CSPAM and behaviour scores between the three clinician groups. It is likely that some of these variations can be explained by the different professional roles of the clinicians, the time spent with patients and perhaps also professional culture. This is the first time nurses were asked for their views in this area, and they have scored higher than doctors and AHPs in the survey. However, we must be cautious in generalising the findings to imply that nurses are more supportive of patient activation as a relatively lower number of nurses responded to the survey though they significantly outnumber doctors in the workforce.

There was no significant variation seen in CSPAM scores by age of clinician within each of the three cohorts in the survey results. However, consultants had a significantly higher CSPAM score than doctors in training. Again, this may be indicative of doctors in training lacking experience or confidence, or may reflect their more transient interaction with individuals, as compared to consultants who might work over a longer period with the same patients enabling them to build relationships and support plans.

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<sup>10</sup> The Kings Fund. Supporting people to manage their health: An introduction to patient activation. Hibbard and Gilbert, May 2014.

## What do clinicians say they do in practice?

The survey also indicates that clinicians vary significantly in terms of their self-reported behaviours and practices towards supporting self-management by people. There is a strong correlation between CSPAM scores and self-reported behaviours, indicating that clinicians that support patient activation are more likely to engage in partnership building behaviours with people.

Among the behaviours studied, clinicians reported that they were most likely to alter their approach according to the patient's level of knowledge, skills and confidence to manage their health. This indicates that clinicians think this was important and that they would take this into account during the consultation.

However, the findings also show that clinicians were least likely to ask people what changes they wanted to focus on. This indicates that perhaps clinicians were more focused on 'what's the matter with you?', and less with 'what matters to you?' The Health Foundation's report, [When Doctors and Patients Talk](#), demonstrates the need for patients and clinicians to have shared priorities to ensure that care provided is person-centred.<sup>11</sup> These findings could therefore highlight an area where further progress is needed.

Time constraint was cited as one of the major barriers towards providing more personalised care, as well as barriers relating to organisational systems, patient abilities and clinicians' own training. The lack of time during consultations is being addressed in many settings, for example, by offering double or triple appointments to people with long term conditions to enable person-centred care planning.

A range of support needs have also been identified by clinicians. To overcome some of the system barriers, clinicians have suggested improved service design with longer appointments for people with greater need and the availability of more local services to support people. Clinicians feel that more flexible models need to be encouraged and implemented to enable them to support people with greater need, that don't focus solely on productivity and throughput. They also indicate that people would benefit from more support and education, which would empower them to take a more active role in the management of their health and care. Additionally, they suggest that skills training in areas such as motivational interviewing techniques and communication skills would help them give more support to people.

All this shows that there is more to be done to support clinicians in providing fully collaborative care which supports patient activation; to unlock system barriers and to support people. We consider these in the next section.

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<sup>11</sup> The Health Foundation report, "When doctors and patients talk: making sense of the consultation", June 2012.

## 6 Implications

This report gives a snapshot of current clinician attitudes and behaviours towards patient activation and it identifies a range of perceived barriers and support needs.

The comments made by clinicians on the survey show that many clinicians believe it is important to address elements across three key areas in the healthcare system to enable the delivery of person-centred care. This includes

- better support for clinicians;
- targeted support for system change; and
- support for individuals to engage in their health and care.

Action is needed right across the health and care system to address these elements. The overwhelming majority of the changes needed can only happen at the local level. But decisions made at the national level also have an impact, either to support or hinder the ability of clinicians to work in a person-centred way. NHS England is working with system partners to remove barriers and create supportive conditions.

One key initiative is the [Coalition of Collaborative Care](#) (C4CC), an alliance of people with long term conditions and health and social care organisations, including the Royal Colleges and the voluntary and community sector, to make person-centred care a norm in the NHS. The Coalition is creating a powerful movement for change across the health and care system, putting people with long-term conditions in control of their health and care.

The Long Term Conditions team at NHS England is working with national clinical directors to engage with clinicians on person-centred care for people living with LTCs. The recently published "[Our Declaration](#)" was developed in partnership with health and care professionals, policy makers and people living with LTCs, and has been endorsed by many organisations and individuals. It sets out the importance of person-centred care for people with LTCs, what needs to change and why we need to change.

NHS England is leading the [Realising the Value Programme](#) as well as a Patient Activation Learning Set, which aim to offer practical approaches to tackling some of these challenges, and assist commissioners, providers, clinicians and individuals to create person-centred care.

NHS England Equality and Health Inequalities Unit will be kept involved to help address any issues related to inequalities in terms of access and health outcomes.

We set out below key actions that NHS England will take and where agreed, the actions that have been committed by our partners.

## 6.1 Support for clinicians

This survey shows that clinicians are variable in their support for patient activation; some have identified development or training needs which could support them to help individuals to take a more active role in their health and care. Some respondents argued that the value of patient activation should be more prominent in clinicians' initial training, and others suggested ongoing support for skills development, for example in the area of motivational interviewing and health coaching.

- The findings will support Health Education England (HEE) in their consideration of training and support for person-centred care, and assist in the development of design principles to support workforce planning, education and training programmes.
- The Royal College of General Practitioners (RCGP) will address the communication skills needs of clinicians in training, guidance and online tools developed through their Collaborative Care and Support Planning programme. Requests for training in communication and motivational interviewing skills will inform their programme for RCGP Network of Champions training and induction event.
- The Nursing division at NHS England will use the findings in their Behaviour Change and Nursing Strategy to support conversations with nurses about what is important to them. They will also work with HEE to include patient activation and behaviour change in their education specification.
- The Realising the Value Programme, funded by NHS England, has a particular strand of work looking at culture change, and this will use behavioural insights to support clinicians, individuals, communities, providers and commissioners to bring about the culture change that is needed in this area.

## 6.2 Support for system change

The findings show that clinicians feel that more needs to be done to enable systems and processes to support them to deliver person-centred care.

- NHS England will use the findings to support its work with the Realising the Value programme – this has a dedicated work stream to consider the system levers and barriers which can support person and community centred approaches to care.
- NHS England will also consider opportunities arising through the New Models of Care and Integrated Personal Commissioning programmes to explore different approaches to redesign.
- The Coalition for Collaborative Care (C4CC) will continue to take action to support local change, and to create the conditions nationally to enable clinicians to work in a person-centred way. The Coalition will also work with leaders at all levels to develop new workforce approaches and strategies, and

identify and help to pull the system and financial levers to remove barriers and incentivise the changes needed to deliver person-centred care.

- The Royal College of General Practitioners (RCGP) has indicated that the appetite for longer appointments for GPs is encouraging for their Collaborative Care and Support Planning programme, and they will aim to work out ways to help practices and Clinical Commissioning Groups (CCGs) free up GPs' time to deliver this.

### 6.3 Support for individuals

Clinicians offered an insight from their experience into the perceived needs of people to support self-management of their health and care. These included people needing better and more reliable information as well as more direct support and education. Some areas are undertaking programmes that are delivering positive outcomes, including peer support, health coaching and health specific education programmes, to provide more direct support to people to engage fully in their health and care. However, the provision of this support is currently patchy.

- NHS England will continue to work with national organisations to improve the quality and accessibility of patient information through The Information Standard and the Accessible Information Standard. NHS England is also initiating cross-cutting work to consider what support can be made available to increase health literacy.
- To increase access to support for self-management and community centred approaches, the Realising the Value programme will aim to identify evidence based approaches and develop tools to support implementation across the NHS and local communities.
- The Coalition for Collaborative Care will work with professional champions, experts and leaders, along with groups of people with long-term conditions to promote a new way of doing things in local areas. They will help communities with practical support including providing information and networking groups for support, learning and training. They will also work with major initiatives and programmes to demonstrate how person-centred, collaborative care can be achieved.

## 7 Conclusion and next steps

The findings give a snapshot of current attitudes across the clinicians surveyed, and provide us with insight that will be built upon in working with clinicians on their support for patient activation. We welcome the positive finding that many clinicians are broadly supportive of patient activation, although there are still a range of attitudes identified. The findings of the survey also point to the fact that while all clinicians have their own individual attitudes towards patient activation, they report significant structural barriers which can sometimes prevent them from being able to practice in a person-centred way.

NHS England will work with key stakeholders - professional bodies, patient representative groups, system leaders, national and local decision makers - to start reflective conversations, to identify how it can work in partnership to address the issues identified in the survey. The findings in this report will support the Royal Colleges and Health Education England in their consideration of training and support for person-centred care, and will assist in the development of design principles to support workforce planning, education and training programmes. The findings will also support NHS England in its work to support the aspiration of the Five Year Forward View to create a health and care service that focuses on the needs and assets of individuals.

Finally, organisations and clinicians can use the survey as a tool to reflect on their attitudes and practices towards supporting people in taking a more active role in their health and care.

## 8 Appendices

### 8.1 Appendix A - PAM and CSPAM measures

#### 8.1.1 A1: Patient Activation Measure (PAM)

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and health care. The Patient Activation Measure (PAM) is a patient-reported measure<sup>12</sup> and has been validated in the United Kingdom<sup>13</sup>. There are four levels of patient activation.

Level 1 - Individuals tend to be passive and feel overwhelmed by managing their own health. They may not understand their role in the care process.

Level 2 - Individuals may lack the knowledge and confidence to manage their health.

Level 3 - Individuals appear to be taking action but may still lack the confidence and skill to support their behaviours.

Level 4 - Individuals have adopted many of the behaviours needed to support their health but may not be able to maintain them in the face of life stressors.

Patient activation scores have been robustly demonstrated to predict a number of health behaviours. They are closely linked to clinical outcomes, the costs of healthcare and people's ratings of their experience. People who have low levels of activation are less likely to play an active role in staying healthy. They are less likely to seek help when they need it and less likely to follow a doctor's advice. They are more likely to attend accident and emergency departments, and to be hospitalised or re-admitted to hospital after being discharged. This is likely to lead to higher healthcare costs. Highly activated people are more likely to adopt healthy behaviour, have better clinical outcomes and lower rates of hospitalisation, and to report higher levels of satisfaction with services.

Evidence has shown that tailoring service delivery according to patient activation levels ensures that the level of support provided is appropriate to the needs of the individual to manage their health. This can maximise productivity and efficiency for the health service.<sup>14</sup>

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<sup>12</sup> Hibbard JH, Stockard J et al. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers. *Health Services Research*. 2004; 39(4 Pt 1): 1005–1026.

<sup>13</sup> The Kings Fund. Supporting people to manage their health: An introduction to patient activation. Hibbard and Gilbert, May 2014.

<sup>14</sup> Hibbard JH, Green J. 'Who are we reaching through the patient portal: engaging the already engaged'. *The International Journal of Person Centred Medicine*, 2011; vol 1, no 4, pp 788–93.



### 8.1.2 A2: Development of CSPAM score and Rasch analysis

In 2009, Judith Hibbard and colleagues adapted the PAM to develop a tool to measure clinician support for patient activation, the CSPAM score. Their study showed that the CSPAM was a reliable way to measure clinician attitudes about the patient role in the care process and all 14 CSPAM items were validated in this study.<sup>15</sup> The measure has been shown to have strong psychometric properties and predictive of clinician behaviours, including behaviours around working in partnership with people.

Rasch models are typically used for assessments that seek to measure things such as abilities or attitudes. This study used Rasch analysis to create the CSPAM score – more information about the methodology can be obtained from [Insignia Health](#).

Rasch measurement is used to create interval-level, unidimensional, probabilistic Guttman-like scales from ordinal data. The measurement model calibrates the difficulty of the items in terms of response probabilities. It creates a measure with a theoretical scoring of 0–100. The calibration of an item on the measurement scale indicates how difficult it is for respondents to endorse or agree to that item. The item calibrations are established separately from the individual respondent scores.

Once the measure is constructed, individuals are measured as to where they fall on the scale, and their location represents how much of the variable each respondent possesses. In the case of the CSPAM, an individual's location indicates how activated the person is. Both the people who are measured and the items doing the measurement are located on the same equal interval scale, yet these two parameters are statistically independent of each other. This concept of parameter separation means that the calibration of the items is independent of the activation levels of the particular respondents measured.

The precision with which an item's scale location, or calibration, has been estimated is represented by the item's standard error of measurement. Likewise, the precision of each individual respondent's estimated scale location is specified by the standard error of measurement of that person.

Item selection is based on item fit statistics representing how much responses to an item deviate from the model's expectations. A fit value of 1.0 indicates perfect fit to model expectations. Fit values >1.0 indicate more stochastic variability in responses than expected - for example, persons with low measured activation endorsing items requiring a high level of activation - and fit values <1.0 indicate that responses to the item by persons of different activation levels do not vary as much as the model expects.

Two-item fit statistics are calculated. Infit is an information-weighted residual and is most sensitive to item fit when the item's scale location is close to the respondent's scale location. Outfit is more sensitive to item fit for items with a scale location that is distant from the respondent's scale location. Simulation studies and experience suggest that item fit values between 0.5 and 1.5 produce sufficient unidimensionality and expected response variability for useful rating scale measurement (Smith 1996). All analyses were conducted with the WINSTEPS Rasch models software application (Linacre 2012).

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<sup>15</sup> Hibbard JH, Collins PA et al. The development and testing of a measure assessing clinician beliefs about patient self-management. *Health Expectations*. 2009; 13: 65-72.

**Model reliability**

Rasch provides an overall person reliability. Person reliability is used to indicate the degree to which a person's response pattern conforms to the model, or difficulty structure of the measure.

Item reliability indicates the degree of confidence in the item difficulty values. This ranges from 0 to 1.0 and represents the degree to which respondents, regardless of their CSPAM score, agree on the item difficulty. It is dependent upon the source of measurement error - either systematic or random. Systematic error comes from measuring something other than the intended construct, such as the tendency to give socially desirable responses. Random error generally reflects sloppy responses from participants.

As it is difficult to know whether the source of measurement error is systematic or random, two reliability values are computed. Real reliability assumes that all the measurement error is systematic. Model reliability assumes that all the measurement error is random. The actual reliability is somewhere in between these two values.

**Data quality in this study**

All items had good to excellent fit to the measurement model expectations and performed very well in measuring CSPAM. Item reliability was high (real 0.99, model 0.99), and the person reliability was also high (real 0.79, model 0.82). These exceeded the minimum level of 0.70. The high item reliability values means that there is a high level of confidence in the measured item difficulties.

## 8.2 Appendix B - CSPAM survey questions

Clinician Support for Patient Activation (CS-PAM) survey					
<p>Patients with long term conditions self-manage their condition at home the majority of the time. They have different levels of knowledge, skills and confidence in managing their own health and care - we describe this as the patient's 'activation' level.</p> <p>Clinicians have different training, orientations and views about a patient's role in their care which results in different approaches when working with people with long term conditions. NHS England is carrying out this survey to understand these views and approaches. It will help in our strategic planning on patient participation and self-management, and identify how we can best support clinicians.</p> <p>Your response is very important and the survey will take less than 10 minutes to complete. The survey closes on 19 December.</p> <p>All responses are anonymous and not associated with any personally identifiable information. Aggregated results from the survey may be published.</p>					
Q 1. As a Clinician, how important is it to you that your patients with long term conditions:	Extremely important	Important	Somewhat important	Not important	Not applicable
a) Are able to take actions that will help prevent or minimise symptoms associated with their health condition(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Understand which of their behaviours make their long term condition better and which ones make it worse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Are able to work out solutions when new situations or problems arise with their health condition(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Tell you the concerns they have about their health even when you do not ask.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please share your thoughts about your responses here:					
Q 2. As a Clinician, how important is it to you that your patients with long term conditions:	Extremely important	Important	Somewhat important	Not important	Not applicable
a) Are able to make and maintain lifestyle changes needed to manage their long term condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Know what each of their prescribed medications is for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Believe that when all is said and done, they are the ones who are responsible for managing their health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please share your thoughts about your responses here:					

Q 3. As a Clinician, how important is it to you that your patients with long term conditions:	Extremely important	Important	Somewhat important	Not important	Not applicable
a) Understand the different treatment options available for their long term condition(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Bring a list of questions (on paper or otherwise) when they come to the clinic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Can follow through on treatments you have told them they need to do themselves at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Are able to determine when they need to go to a health professional for care and when they can manage the problem on their own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share your thoughts about your responses here:

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Q 4. As a Clinician, how important is it to you that your patients with long term conditions:	Extremely important	Important	Somewhat important	Not important	Not applicable
a) Want to be involved as a full partner with you in making decisions about their care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Want to know what procedures or treatments they will receive and why before the treatments or procedures are performed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Look for trustworthy sources of information about their health and health choices, such as on the web, news stories, or books.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share your thoughts about your responses here:

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The following questions are about your current practice when working with people with long term conditions.

Q 5. When working with people who live with long term conditions,	Always	Mostly	Sometimes	Never	Not applicable
a) Do you consider their level of knowledge, skills and confidence to manage their health between appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you seek to alter your approach according to their level of knowledge, skills and confidence to manage their health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Do you seek to identify their personal goals and develop action plans with them to achieve these?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Do you alter the care and support you offer to reflect individual values and preferences?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment on the approaches you use or what tools/information would be useful to you:

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Q 6. When working with people who live with long term conditions,	Always	Mostly	Sometimes	Never	Not applicable
a) Do you try to understand their information needs, and tailor information provision to meet those needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you understand their psychological and social support needs as part of the care you provide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you able to signpost them to other services that address their psychological and social support needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment on the approaches you use or what tools/information would be useful to you:

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Q 7. In the last six months, when treating people with long term conditions, how often did you	Always	Mostly	Sometimes	Never	Not applicable
a) Ask them what change they wanted to focus on?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Commend them when they made even small behavioural improvements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suggest multiple changes in their self-management behaviours during a single consultation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share your thoughts about your responses here:

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### 8.3 Appendix C - Demographic characteristics of clinicians

Table 3: Distribution of survey respondents

Distributi on by	Variable	Doctors			Nurses			AHPs		
		No. (n=778)	%	Demog raphic distribu tion*	No. (n=595)	%	Demog raphic distribu tion*	No. (n=386)	%	Demog raphic distribu tion*
Gender	Male	388	51%	54%	55	9%	10%	52	14%	24%
	Female	381	49%	46%	538	91%	90%	329	86%	76%
Age	Under 35	83	11%	39%	42	7%	26%	95	25%	37%
	35-44	205	26%	30%	116	20%	29%	96	25%	29%
	45-54	256	33%	21%	319	54%	32%	116	30%	24%
	55-64	174	22%	10%	114	19%	17%	77	20%	13%
	65+	57	7%	4%						
Ethnicity	White	607	79%	60%	571	95%	80%	362	94%	92%
	All minority ethnic groups	163	21%	40%	28	5%	20%	25	6%	8%
Region	East Midlands	70	9%	7%	67	12%	8%	29	8%	8%
	East of England	80	11%	9%	67	11%	9%	47	12%	9%
	London	101	13%	21%	33	6%	16%	30	8%	16%
	North East	50	7%	6%	49	8%	6%	36	9%	5%
	North West	93	12%	13%	89	15%	16%	63	16%	15%
	South East	148	19%	16%	108	19%	15%	87	23%	16%
	South West	94	12%	8%	84	14%	8%	39	10%	9%
	West Midlands	70	9%	10%	41	7%	11%	30	8%	11%
Yorkshire & Humber	63	8%	10%	52	9%	10%	22	6%	10%	
Years in practice	0-5	35	5%		24	4%		62	16%	
	6-10	75	10%		47	8%		51	13%	
	11-15	104	13%		71	12%		72	19%	
	16-20	114	15%		67	11%		46	12%	
	21-30	236	31%		209	35%		85	22%	
	31+	208	27%		174	29%		68	18%	

\*Data source: HSCIC 2014 Workforce census: Includes data for doctors and dentists; Qualified nurses (and midwives, health visitors); Qualified AHPs including ambulance service staff (as on 30 Sep 2014)

Table 3 shows that the survey population is broadly consistent with the general clinician population across the three groups – with some under representation of younger age and minority ethnic groups. Some regions are more represented than others in the sample.

### 8.3.1 Inclusion/exclusions from study:

- Of the 1797 clinicians who responded to the survey, 38 clinicians (16 doctors, 14 nurses and 8 AHPs) gave extreme positive answers to all questions – they were excluded from the analysis as they could simply have been engaging in the response set and not participating fully in the survey. 1759 (97.9 percent) clinicians in the survey participated completely in the data collection and answered all 14 CSPAM items – this was a very high level of participation in the survey.
- Doctors working in public health (n=3) who have little direct involvement with patients were excluded from the study.
- 88 percent of the clinicians primarily provided care for LTC patients. The data was analysed separately for clinicians who primarily cared for people with LTCs or not. No significant variation was seen between the scores of the two groups (Table 4), so all respondents were included in the analysis.

Table 4: Variation in CSPAM scores for clinicians who cared primarily for LTCs or not

Variation in CSPAM scores by		Doctors	Nurses	AHPs
Primarily caring after LTCs	Yes	69.8 (n=695)	75.5 (n=552)	72.1 (n=302)
	No	70.7	76.3	70.6
	Significance	F<1	F<1	F<1

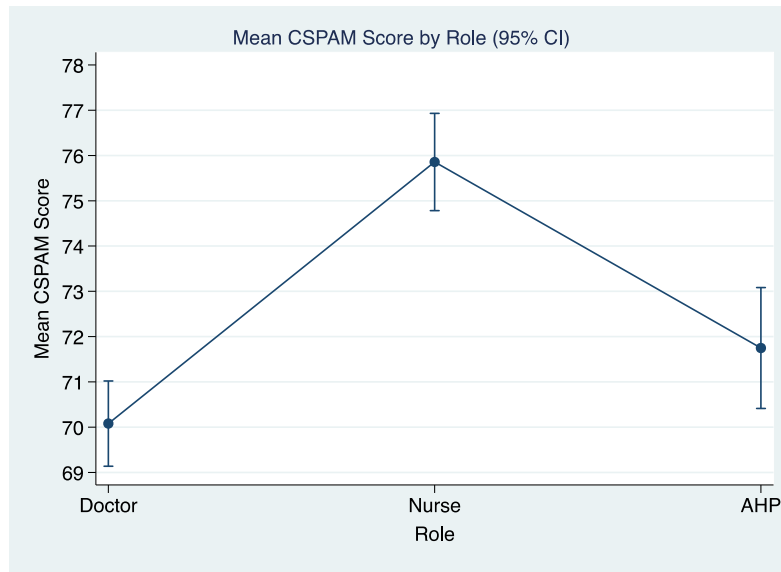
## 8.4 Appendix D - CSPAM scores and partnership building behaviours of clinicians

### 8.4.1 D1: Variations in CSPAM scores for doctors, nurses and AHPs

Mean CSPAM score for Doctors = 70.1; Nurses = 75.9; and AHPs = 71.7

Nurses had a significantly higher score compared to doctors and AHPs ( $F=31.98$ ,  $p < .00001$ ). There was no significant difference between the scores of doctors and AHPs (Figure 4).

Figure 4: Mean CSPAM scores by role





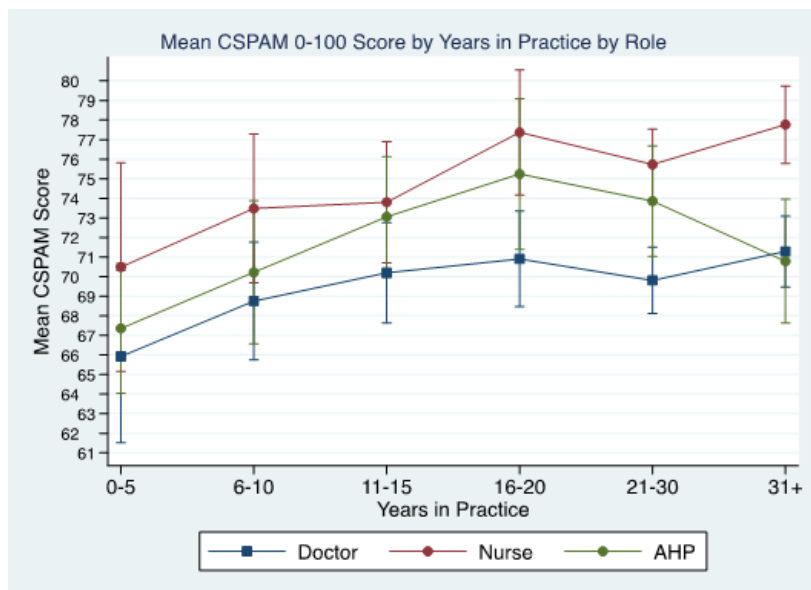
Within the three cohort groups, the demographic variations are shown in Table 5.

Table 5: Demographic variation in CSPAM scores by role

Variation by		Doctors	Nurses	AHPs	Variation by		Doctors	Nurses	AHPs
Gender	Male	69.7	74.6	69.4	Region	East Midlands	67.4	75.3	74.5
	Female	70.2	75.7	72.0		East of England	70.0	78.1	70.2
	Significance	F<1	F<1	F=1.90 p=0.169		London	71.6	74.7	72.5
Age range	Under 35	65.9	74.3	68.0		North East	70.1	73.5	73.5
	35-44	69.8	75.0	73.0		North West	70.6	74.8	71.1
	45-54	70.8	75.4	73.6		South East	70.9	75.9	71.0
	55-64	70.7	77.4	71.9		South West	69.1	75.7	71.1
	65+	69.6				West Midlands	67.6	74.9	71.5
	Significance	F=2.23 p=0.065	F<1	F=3.00 p=0.02		Yorkshire & Humber	70.5	76.4	72.8
				Significance	F<1	F<1	F<1		

There was no significant difference in CSPAM scores within the three cohorts (doctors, nurses and AHPs) by gender, age, region or years of practice (Figure 5).

Figure 5: Mean CSPAM scores by years in practice by role



### 8.4.2 D2: Difficulty structure of CSPAM items

The item calibrations indicate, in a probabilistic sense, how difficult it is for a respondent, or how much activation is required, for a clinician to endorse or agree to that item. Item scale locations are shown on a 0–100 metric. While the metric allows for a potential range of 0–100, the items included in the measure covered the range from 33–70, not tapping what would be theoretically the lowest or highest ranges of the construct. The items at the low end are the ones easiest for clinicians to endorse (or indicate it is important). The items at the high end are the ones least likely to be endorsed by clinicians.

Based on the difficulty scores in the 2009 study, the 14 CSPAM items were grouped together into four competencies that are important for people to take a more active role in their health and care.

Table 6: Difficulty structure of CSPAM items by clinician role

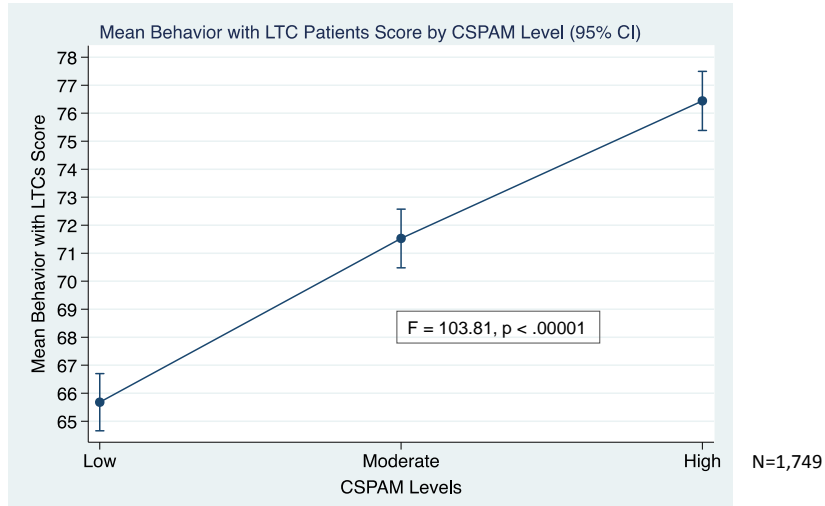
As a clinician, how important is it to you that your patients:	All clinicians	Doctors	Nurses	AHPs	GPs only
<b>Manage behaviours &amp; lifestyles and follow clinical advice</b>					
1. Are able to take actions that will help prevent or minimise symptoms associated with their health condition(s).	37	37	36	36	36
2. Are able to make and maintain lifestyle changes needed to manage their long term condition.	43	41	45	42	39
3. Understand which of their behaviours make their long term condition better and which ones make it worse.	36	36	36	33	34
4. Can follow through on treatments you have told them they need to do at home.	50	50	52	47	51
<b>Can make independent judgement and actions</b>					
5. Know what each of their prescribed medications is for.	47	46	47	52	45
6. Believe that when all is said and done, they are the ones responsible for managing their health.	55	51	59	55	48
7. Are able to determine when they need to go to a medical professional for care and when they can manage the problem on their own.	49	49	48	49	45
8. Are able to work out solutions when new situations or problems arise with their health condition(s).	49	49	49	50	49
<b>Able to function as member of the care team</b>					
9. Want to be involved as a full partner with you in making decisions about their care.	52	55	50	51	55
10. Tell you the concerns they have about their health even when you do not ask.	44	45	42	45	46
11. Want to know what procedures or treatments they will receive and why before the treatments or procedures are performed.	52	53	50	52	56
12. Understand the different treatment options available for their long term conditions.	49	51	47	48	53
<b>Is an independent information seeker</b>					
13. Look for trustworthy sources of information about their health and health choices, such as on the web, news stories or books.	61	60	61	62	57
14. Bring a list of questions (on paper or otherwise) when they come to the clinic.	65	66	64	66	70

Difficulty structure: Easiest shaded blue; hardest shaded pink

**8.4.3 D3: Relationship between behaviour composite and CSPAM level**

Scores for a composite behaviour with LTC patients' measure across study groups differed significantly by level of CSPAM activation (Figure 6).

Figure 6: Mean behavior scores by CSPAM levels

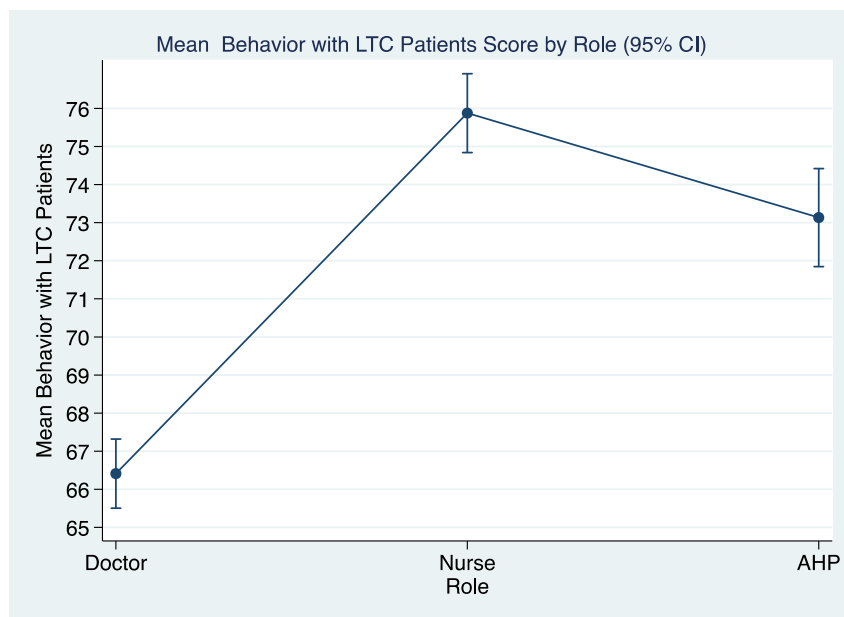


**8.4.4 D4: Partnership building behaviours of clinicians**

Mean composite behavior score for Doctors = 66.4; Nurses = 75.9; and AHPs = 73.1

Figure 7 shows that nurses have a significantly higher score compared to doctors and AHPs; AHPs have significantly higher scores than doctors ( $F = 6.93, p = 0.009$ ).

Figure 7: Composite behavior scores by role



Nurses are significantly more likely than doctors and AHPs to say that they ‘always’ engage in patient-centred behaviours (Figure 8).

- 80 percent of the nurses said that they always altered support based on the patient’s knowledge, skills and confidence. 72 percent of the nurses said that they always tried to find the patient’s information needs and tailored information to support those needs.
- Like nurses, a high rate of AHPs said they always altered support based upon a patient’s knowledge, skills and confidence. 57 percent of doctors did so.
- Less than half the doctors said that they ‘always’ practiced other partnership building behaviours.

Figure 8(a): Responses to behaviour questions by role

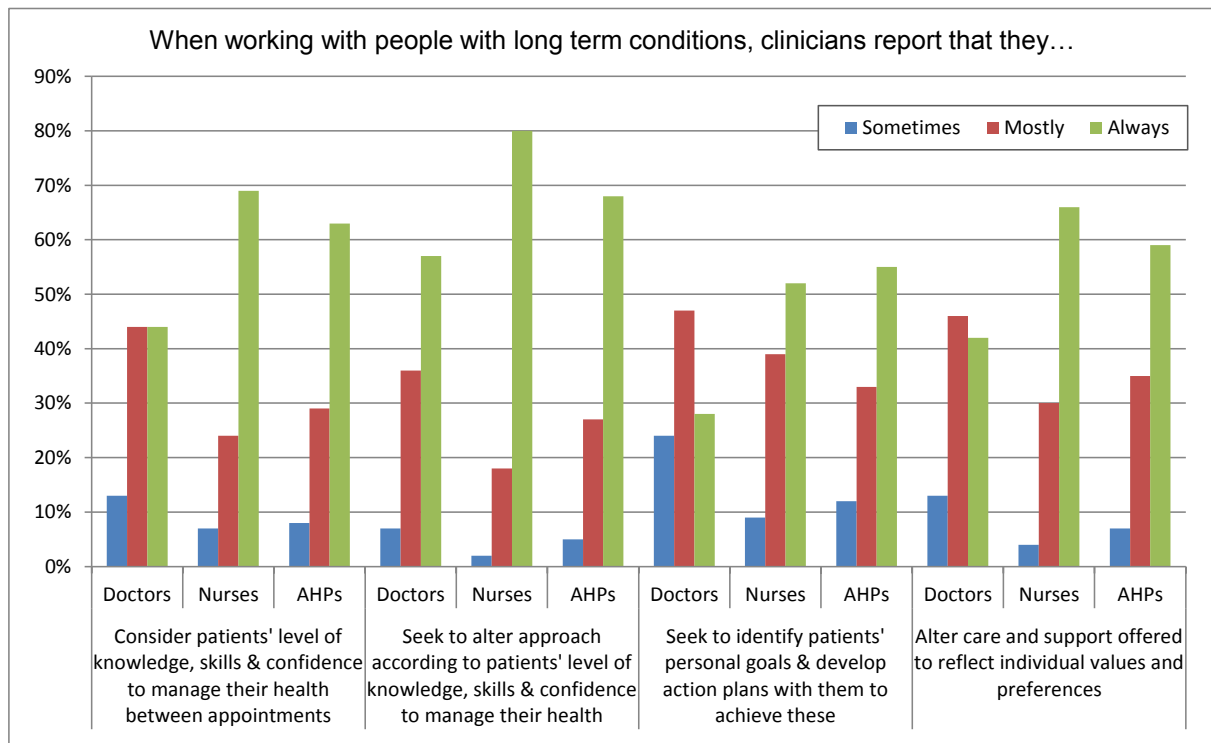


Figure 8(b): Responses to behaviour questions by role (Continued)

