

# The MAGIC programme: evaluation

An independent evaluation of the MAGIC (Making good decisions in collaboration) improvement programme



**Evaluation**  
April 2013

**Authors**

Ewan King  
Jean Taylor  
Rebecca Williams  
Tim Vanson

**Organisation**

Office for Public Management  
252b Gray's Inn Road  
London  
WC1X 8XG  
[www.opm.co.uk](http://www.opm.co.uk)

**Contact**

Ewan King  
020 7239 0872  
[eking@opm.co.uk](mailto:eking@opm.co.uk)

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# Health Foundation commentary

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How do you get shared decision making into practice? Despite a growing body of evidence that highlights the benefits of shared decision making<sup>1</sup> and a growing political, professional and patient consensus in its favour,<sup>2</sup> embedding shared decision making into the day-to-day reality of hard-pressed health services remains a challenge.

A small group of passionate frontline staff, managers and academics in NHS sites in Newcastle and Cardiff joined together in the MAGIC (Making good decisions in collaboration) programme to take on this challenge, seeking to implement and embed shared decision making at individual, team and organisation level.

The Health Foundation funded their work because we want a more person-centred healthcare system; one that supports people to make informed decisions about, and successfully manage, their own health and care, including choosing when to let others act on their behalf. We want a system which delivers care that is responsive to people's individual abilities, preferences, lifestyles and goals.

This independent evaluation investigates how the MAGIC teams got on. It is a rich resource that synthesises learning and captures the complex interaction between individual beliefs and behaviours, professional identities and system dynamics that can help or hinder shared decision making.

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<sup>1</sup> See, for example: The Health Foundation. *Helping people share decision making*. The Health Foundation, 2012. [www.health.org.uk/publications/helping-people-share-decision-making](http://www.health.org.uk/publications/helping-people-share-decision-making)

<sup>2</sup> See, for example: Health and Social Care Act 2012; Charter of Patient Rights & Responsibilities, Scottish Government; 'Shared decision making: A summary of learning from the event, 3 November 2011' – Royal College of Physicians; National Voices' response to 'Liberating the NHS: no decision about me without me', August 2012

The evaluation provides important insights into professionals' motivations for adopting – and, indeed, for resisting – shared decision making. Some were not convinced of the benefits of patients having more voice in decisions about their care. Others were driven by motivations as providers of healthcare: to reduce the risk of litigation, to increase compliance, to reduce consultation rates. For others, however, adoption of shared decision making was clearly driven by a desire to support patients to understand their options and make choices on the basis of their values and in the context of their individual circumstances and relationships.

The evaluation also provided insights into barriers to implementing shared decision making from a patient's perspective. For example, for some patients, expectations of deferring to clinical authority are ingrained: the programme stopped giving satisfaction questionnaires to patients before a consultation as the patients often filled them in saying they were satisfied before seeing the doctor or nurse, highlighting the limitations of patient satisfaction tools. This deference might be compounded by low health literacy, self-efficacy and confidence, putting some groups at potential disadvantage unless health services and healthcare professionals pay attention to the issue.

Systems, too, are not yet designed to support shared decision making: one team felt that shared decision making would be supported if certain service users had information in advance, but there was no easy way to identify the relevant service users. Designing systems to support shared decision making also requires broader incentives, such as the Quality and Outcomes Framework, to be better aligned with supporting it.

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While this evaluation helps us understand the social, psychological and system challenges to implementing shared decision making, it also provides some very practical learning about how to overcome them. The report shows the factors that can result in:

- clinicians having a ‘lightbulb’ moment, when they understand what shared decision making really is
- patients taking decisions that reflect their values and preferences
- organisations putting in the infrastructure and support necessary for change.

Embedding shared decision making can be hard and slow, but it can also create positive change within health systems and in the lives of patients.

The evaluation also confirms the vital role of training clinicians in shared decision making, complementing learning from our Co-creating Health programme.<sup>3</sup> Not only can training increase knowledge and understanding of shared decision making, but it can also help clinicians see afresh the reality of their own behaviours. The MAGIC programme found that, whilst many health professionals thought they were ‘doing it already’, once they really understood what shared decision making is, they realised that it is more than good communication skills and involves a different type of relationship. Role play and a facilitative learning approach, which enables participation and reflection so that clinicians can diagnose and resolve issues themselves, also had a powerful part to play in this awakening. Working with and training multi-professional teams create a shared goal and momentum for change, making changes more likely to stick; training individuals in isolation from their peers can leave them without sufficient leverage to enact change.

This evaluation reinforces the imperative to take a multi-faceted approach that addresses attitudes, behaviours and infrastructure. Information, decision aids and measurement tools may be necessary to implement shared decision making. However, whether those tools are effective or not will be determined by an attitude, among both clinicians and patients, that sees decisions belonging to the patient, as well as the behavioural repertoire to support patients to make informed decisions that meet their priorities and preferences.

If we are to fulfil the Wanless vision of a ‘fully engaged patient’,<sup>4</sup> supporting people to make decisions about their health and healthcare that are right for them, then we all have much to do. Commissioners and service planners need to design services around the patient’s journey, rather than around the organisation that provides care. They need to ensure that programmes which support people to develop their health literacy, and to have the confidence to act as equal partners in their care and treatment, are embedded in those pathways. NHS England needs to lead the way to developing robust and meaningful measures of patient participation in decision making, and designing payment systems to reward partnership better. Health Education England, Local Education and Training Boards, NHS Education for Scotland, the professional regulators, royal colleges and education institutions all have their part to play in developing education and training that will enhance clinical skills in supporting people to take decisions about their health and healthcare.

The MAGIC programme and its evaluation offer, both through the teams’ successes and from their challenges, valuable insights and a richness of practical resources. These resources can support individuals, teams and organisations put shared decision making into practice, enabling them to transform services to embed mutual responsibility.

The two teams in Newcastle and Cardiff are now more than halfway through the second phase of the MAGIC programme. They are developing their models to support a change in culture, a change in practice and the adoption of tools and behaviours that will enable a new relationship between people and health services. We will continue to share the lessons and resources from their work on our shared decision making resource centre ([www.health.org.uk/sdm](http://www.health.org.uk/sdm)).

**Adrian Sieff**  
**Assistant Director**  
**The Health Foundation**

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<sup>3</sup> The Health Foundation. *Co-creating Health: Evaluation of the first phase*. The Health Foundation, 2012.  
[www.health.org.uk/publications/co-creating-health-evaluation-phase-1](http://www.health.org.uk/publications/co-creating-health-evaluation-phase-1)

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<sup>4</sup> Wanless D. *Securing Our Future Health: Taking a Long-Term View, Final Report*. HM Treasury, 2002.  
[www.hm-treasury.gov.uk/consult\\_wanless\\_final.htm](http://www.hm-treasury.gov.uk/consult_wanless_final.htm)



# The MAGIC programme: evaluation

April 2013

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# Executive summary

## Introduction

The Health Foundation's MAGIC (Making good decisions in collaboration) improvement programme began in August 2010 and will run until October 2013. It aims to support clinical teams in primary and secondary care to embed shared decision making (SDM) with patients in their everyday practice. This evaluation covers the first phase of the programme.

The Health Foundation commissioned a consortium of experts to implement the programme, led by Professor Glyn Elwyn at Cardiff University and Professor Richard Thomson at Newcastle University. Clinical teams were invited to participate from primary and secondary care settings across two NHS sites: [Newcastle upon Tyne Hospitals NHS Foundation Trust](#) and [Cardiff and Vale University Health Board](#).

## About the evaluation

This independent evaluation of the MAGIC programme was conducted by the Office for Public Management (OPM). The main aim was to explore the process through which SDM was implemented, eliciting insights about what worked well and what worked less well – and in what circumstances – rather than establishing the impact of the programme on measurable outcomes.

The evaluation findings are based on a range of data, including the development of a programme logic model, observations at MAGIC team meetings, in-depth interviews with participants and stakeholders, an online survey of clinical teams and interviews with patient representatives. In-depth interviews with staff and patients formed the basis for seven improvement stories, published in the Health Foundation learning report *Implementing shared decision making* ([www.health.org.uk/publications/implementing-shared-decision-making](http://www.health.org.uk/publications/implementing-shared-decision-making)).

## The MAGIC improvement programme

### Programme aims and objectives

The aims of the MAGIC programme are:

- to demonstrate that shared decision making (SDM) can feasibly, affordably and sustainably become a core characteristic of routine clinical care, both within primary and secondary care and at large scale
- to build practical and transferable knowledge about how this can be achieved and what the conditions for success are.

### Programme activities

The programme was delivered through activities including:

- skills development and engagement, such as introductory and advanced skills development workshops for participating clinicians
- guidance on developing, adapting and implementing decision support tools
- facilitation and peer support for clinical teams

- support in involving patients, including setting up patient forums and implementing a campaign – Ask 3 Questions – to ‘activate’ patients (increase their awareness of SDM).

## Key findings

### Creating the right leadership, culture and behaviours to implement SDM

The evaluation found evidence that the programme has succeeded in building participants’ understanding and awareness of SDM, and developing their skills and confidence to apply the approach in practice. However, it proved difficult to successfully engage a small number of stakeholders, particularly senior clinicians. These stakeholders demonstrated a continued reluctance to engage fully with the programme, partly due to perceptions that SDM would be too time consuming. Some clinicians needed to see more evidence to be persuaded to adopt SDM – particularly evidence of its impact on clinical and patient outcomes.

Programme activities that were successful in building ownership and supportive behaviours in relation to SDM included:

- getting buy-in from senior leaders, board members, strategic managers and commissioners
- sharing available evidence (including the patient experience and feedback wherever possible) on the difference SDM can make to outcomes, and its benefits for patients and clinicians alike
- tapping into different staff motivations to improve interactions with patients
- ensuring that all clinical staff benefit from SDM training, with advanced skills training for specific staff (using role play and sharing practical skills to apply SDM)
- training project teams in quality improvement (QI) methods
- using local facilitators (clinical peers with relevant knowledge, experience and enthusiasm) to support others implementing SDM.

Success was more likely where SDM was aligned with broader objectives such as developing more patient-centred care. Encouraging ownership and buy-in from the start, from the full range of staff involved in implementation, proved vital, as did the commitment and vision of enthusiastic leaders who were able to keep SDM high on the organisation’s agenda. Local clinical champions played a key role, and local facilitators were helpful in providing regular encouragement and support to colleagues involved in implementation.

### Delivering and embedding SDM in clinical settings

The evaluation found that the MAGIC programme successfully supported clinical teams to test and develop a range of SDM tools, approaches, and changes to clinical practice. This included decision quality measures (DQMs), shared decision making questionnaires (SDMQ) Option Grids, Brief Decision Aids (BDAs) and marketing campaigns. Many of the decision support tools and other inputs (such as the Ask 3 Questions campaign materials) have proved useful and popular, incentivising staff to develop and refine their own tools. By promoting the use of decision support tools that are tailored to different settings and conditions, the programme has helped clinical teams to build a more systematic and consistent approach to conducting patient conversations.

While it was not possible to assess which had the most impact, there was widespread use and positive feedback on many of the tools piloted within the programme. This is especially true of brief in-consultation decision support materials (Option Grids, Brief Decision Aids

(BDAs)), which were widely reported as being simple to use, effective in promoting consistent practice across clinical teams, and easy for patients to engage with.

The evaluation found that quality improvement (QI) methods were regarded as an effective approach to implementing changes and new tools. However, not all participants had pre-existing knowledge of QI, so training in quality improvement should be made available to all clinicians engaged in implementation at an early point in similar programmes in the future.

The MAGIC programme achieved some progress in supporting staff to redesign care pathways in order to reflect SDM. However, more work will be required to explore how care pathways need to be redesigned to embed SDM, especially in primary care.

The evaluation found that assessing the baseline or 'starting point' of local teams, including their motivation and readiness to engage with SDM, may result in more tailored and therefore more effective approaches to implementation. The organisational context in the two programme sites, Cardiff and Newcastle, differed in key respects, particularly the teams' level of familiarity with QI methodologies and support from the board – both of which were felt to ease implementation of SDM. Local teams also differed in terms of their preference for receiving direction from the core MAGIC team and being given significant levels of autonomy.

## Creating a health system that is ready for SDM

For many clinicians involved in the programme, the training and skills workshops they attended led them to question their assumption that they were already delivering SDM. The programme gave them the opportunity to hear the patient experience of SDM and conduct role play exercises. This helped them make the connections between the theory of SDM and the reality of their routine clinical practice.

There are a number of lessons emerging from this evaluation about what may be needed to support the wider roll-out of SDM so that it becomes embedded across the NHS.

Changes likely to produce a solid foundation for the implementation of SDM include:

- stronger and more widespread efforts to raise patients' awareness of and capacity to engage with SDM (including support to patient representative groups)
- the creation of mapping tools to enable service managers and commissioners to understand how care pathways can support SDM and where the decision points lie
- the development of national measures that can enable NHS managers to monitor and track patient experiences of SDM and outcomes
- provision of training and development programmes to support SDM, available to clinicians at all levels in the system
- the re-development of NHS and local authority information systems such as GP and NHS trust software systems so that SDM tools and information are readily available to clinicians and to patients, through patient records.

It is important that those responsible for commissioning health services gain a deeper understanding of what is required for SDM. Commissioning strategies and business plans also need to clearly identify how they can contribute to strengthening SDM, with robust processes for monitoring progress and embedding SDM across services and care pathways.

# 1. Introduction

## 1.1 About shared decision making

Shared decision making is a process in which clinicians and patients work together to choose tests, treatments, management, or support packages, based on clinical evidence and patients' informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and systems for recording and implementing patients' treatment preferences. It is appropriate in any healthcare setting in which more than one option is available, including the option to do nothing.

MAGIC is one of a range of approaches that have emerged over the past decade to support people to become more involved in their own care, with varying degrees of success. They include providing accessible information, decision support aids, information prescriptions and communication skills training for patients and professionals. Research from the UK and other countries suggests that strategies to enhance the delivery of SDM can improve:

- people's **knowledge** about their condition and treatment options
- people's **involvement** in their care
- people's **satisfaction** with care
- people's self-**confidence** in their own knowledge and self-care skills
- professionals' **communication**.

Policy makers and clinicians are interested in SDM because it may contribute to better relationships between patients and professionals, and improved long-term health outcomes. These outcomes are especially important in the context of unprecedented financial challenges to the delivery of healthcare and the pressure to make the best possible use of staff and other resources. SDM can also help clinicians to meet the ethical imperative of ensuring that patients understand the treatment and care options available to them.

There is some evidence based on previous initiatives about what activities can support the implementation and embedding of SDM within clinical settings. These may include:<sup>1</sup>

- **decision aids** in many formats
- **goal setting** and care planning
- **support** sessions for patients
- **training** for professionals in relevant skills.

Further, initiatives that encompass multiple elements are more likely to be successful. As the Health Foundation's evidence review notes:

*Initiatives can be categorised along a continuum, with passive information provision at one end and initiatives that actively seek to support patients at the other... Research suggests that information provision... alone [is] unlikely to be sufficient to motivate ongoing shared decision making. Instead, more active support from professionals is needed.*

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<sup>1</sup> The Health Foundation (2012) *Helping people share decision making*. London: The Health Foundation.

There is a growing evidence base on the barriers and facilitators to the implementation of SDM, and this evaluation sought to build on rather than replicate these. Key barriers and facilitators are outlined in the box below.<sup>2,3</sup>

<b>Barriers and facilitators</b>	
<p><b>Barriers</b></p> <ul style="list-style-type: none"> <li>• Paternalistic healthcare culture</li> <li>• Perceived lack of time in consultations</li> <li>• Perception among clinicians that SDM is not appropriate for their patients</li> <li>• (Perceptions of) appropriateness in specific clinical settings</li> <li>• Insufficient tools and resources to support SDM</li> </ul>	<p><b>Facilitators</b></p> <ul style="list-style-type: none"> <li>• Provider motivation</li> <li>• Positive impact on the clinical process</li> <li>• Patient outcomes</li> <li>• Good leadership</li> <li>• Formal training</li> <li>• Appropriate infrastructure</li> </ul>

There is an interest in exploring how SDM can be applied more systematically in consultations or other encounters between clinicians and patients, at least in some form.<sup>4</sup> There is also a recognition that we need to understand more about how to effectively implement SDM within clinical settings, and in particular, how to ensure that patients and professionals alike support and see the value of SDM by facilitating a change in culture, behaviours and attitudes.<sup>5</sup>

## 1.2 The MAGIC programme

The MAGIC programme is an 18-month improvement programme that started in August 2010. Initially due to finish in January 2012, it has now been extended until October 2013.

MAGIC has worked with frontline health professionals in two sites across the UK. It was established to develop and test practical solutions that support patients and healthcare professionals working together to make decisions about treatment and care, and to embed SDM within everyday clinical practice. In the words of one of the members of the MAGIC core design team, *'This programme was about how to put shared decision making into practice in real world clinical environments ... and learning about the challenges of doing SDM and what works.'*

Since MAGIC aimed to implement practice previously evaluated and evidenced in academic studies, including the evaluation of a range of decision aids, the programme has acted as a knowledge translation project. This evidence is available in the MAGIC programme scoping study.<sup>6</sup>

<sup>2</sup> The Health Foundation (2012) *Helping people share decision making*. London: The Health Foundation.

<sup>3</sup> Coulter A. (2009) *Implementing shared decision making in the UK*. London: The Health Foundation.

<sup>4</sup> Coulter A, Collins A. (2011) *Making shared decision-making a reality: No decision about me, without me*. London: The King's Fund.

<sup>5</sup> The Health Foundation (2012) *Helping people share decision making*. London: The Health Foundation.

<sup>6</sup> Coulter A. (2009) *Implementing shared decision making in the UK*. London: The Health Foundation.

A considerable body of research has been conducted into the use of decision aids or decision support tools in the NHS to enhance SDM. While the MAGIC programme tested the use of decision aids as part of its work, the programme had a much wider remit, which involved identifying ways to change attitudes and culture within the health service and inspire staff to work closely with patients using SDM.

## **MAGIC programme aims, objectives and outcomes**

### **Aims**

The MAGIC programme had two specific aims:

- to demonstrate that SDM can feasibly, affordably and sustainably become a core characteristic of routine clinical care, both within primary and secondary care, and at large scale
- to build practical and transferable knowledge about how this can be achieved and what the conditions for success are.

### **Objectives**

The specific aims of the MAGIC programme were:

- to raise awareness of SDM and its potential benefits for improving the patient experience, cost effectiveness, quality and safety
- to embed SDM into current systems and clinical pathways
- to commit senior management teams to supporting the concept of patient involvement in decision making as a fundamental value that underpins the work of their organisation and to start realigning incentives and performance measures accordingly
- to increase the extent to which patients perceive themselves to be involved in their care (key decisions)
- to engage a number of clinical teams such that they become advocates of SDM within the larger organisation, sustain the approach beyond the end of the project, and feel motivated to promote SDM to colleagues, internally and externally
- to capture sufficient learning about the determinants of success and failure in order to inform and roll out an implementation process.

### **Immediate effects**

In the following section on our methodology, we describe how the evaluation – through the process of the programme logic model – identified a series of intended programme outcomes, which included the following.

- That most, if not all staff at the recruited clinical teams will have become aware of SDM and that many will know of the benefits that can be achieved in terms of improving the patient experience, cost effectiveness, quality and safety.
- That senior management teams (clinical and non-clinical) will have committed themselves to supporting the concept of patient involvement in decision making as a fundamental value that underpins the work of the organisation, and will have begun the process of aligning incentives and performance measures accordingly.
- That several clinical teams are engaged in the drive to implement SDM such that they have become advocates of SDM within the wider organisation.

- That learning about the determinants of success and failure is captured to help others replicate this.
- That each participating team will have used and embedded routine monitoring of key indicators of progress into their areas of clinical practice.
- Sustainability of SDM work within clinical teams is the ultimate success indicator.

### **Longer-term outcomes**

While it was not within the scope of this evaluation to conduct an assessment of the programme's impact on patient outcomes, the MAGIC programme anticipated over the longer term that SDM would lead to better outcomes for patients, including:

- increased wellbeing
- being better informed about choices and able to take better decisions
- higher levels of clinical engagement and satisfaction
- better processes and systems for measuring the ongoing impact of SDM.

### **MAGIC programme settings**

The Health Foundation commissioned a consortium of experts to lead the programme, referred to throughout this report as the MAGIC core design team. The team was led by Professor Glyn Elwyn at Cardiff University and Professor Richard Thomson at Newcastle University, who were tasked with implementing a programme that would explore how SDM can be embedded in both primary and secondary care settings in two NHS sites: [Newcastle upon Tyne Hospitals NHS Foundation Trust](#) and [Cardiff and Vale University Health Board](#).

Teams were recruited to take part in the programme from the following clinical settings:

#### *Newcastle*

- Primary care (general practice)
- Breast cancer care
- Obstetrics
- Urology

#### *Cardiff*

- Primary care (general practice)
- Breast cancer care
- Ear, nose and throat

More than 270 staff have taken part in the programme, drawn from a range of clinical and non-clinical backgrounds, including nursing, NHS management and general practice.

### **MAGIC programme support**

The MAGIC programme provided a range of support to the clinical teams across the two sites, as follows.

## **Skills development and engagement**

MAGIC delivered a number of introductory and advanced skills development workshops to participating clinicians. The workshops explored how SDM can benefit the clinician and the patient and build clinicians' skills in using the techniques needed for this approach. In parallel, the team sought to increase awareness and commitment to the programme among senior managers, taking part in presentations, meetings and discussions with this aim in mind.

## **Support with implementing decision support tools**

MAGIC assisted a number of clinical teams with developing and implementing various forms of decision support tools. In some cases, this involved helping teams make better use of existing decision support tools. In other cases, where decision aids were not available, the programme supported teams to work on brief in-consultation decision support tools such as Option Grids and BDAs..

## **Development of marketing campaigns**

MAGIC worked with teams to develop a number of marketing campaigns to increase organisational and patient awareness of SDM, including through a website, marketing materials and the Ask 3 Questions campaign (see section 3.3).

## **Facilitation and peer support**

Throughout the programme, the MAGIC team worked directly with clinical teams to support them with specific projects and interventions. They also facilitated a number of exchange visits and action learning sessions that brought clinicians from different projects to work together on common issues. Local clinical team leads were regularly involved in local design team (LDT) meetings, which aimed to help participants share learning across the participating teams. The core design team (CDT), made up of the core MAGIC teams from both sites, also met regularly to review the overall implementation of the programme and share learning.

## **Support to involve patients**

MAGIC has delivered a number of activities to enable teams to increase the level of patient involvement in SDM. These included setting up and consulting a patient and public involvement (PPI) panel, and implementing a campaign (Ask 3 Questions) to increase patient awareness of SDM.

## **1.3 About the evaluation**

In August 2011, the Health Foundation commissioned the Office for Public Management (OPM) to conduct an 18-month evaluation of the MAGIC programme. The main aim of the evaluation was to assess how, and to what extent, the MAGIC programme has been able to embed SDM within clinical settings.

The evaluation methods are couched within a theory of change evaluation framework. The 'theory of change' approach, which is one of a family of theory-based evaluation approaches, enables an evaluation to surface the theoretical or logical sequences by which an intervention – in this case the MAGIC programme – is expected to bring about its desired effects. In order to build this theory, the OPM team prepared a bespoke model in collaboration with MAGIC that denoted the high-level drivers that informed the programme, the main programme activities, and its desired effects and outcomes.

The methods deployed in this evaluation were largely qualitative, and we did not deploy an experimental design that would enable us to establish the counterfactual (that is, what would have happened if the programme did not exist). Therefore, the primary focus of this evaluation was to explore the 'process' through which SDM was implemented, eliciting insights about what worked well, what worked less well, and in what circumstances, rather than establishing the impact of the programme on measurable outcomes.

## **Evaluation activities**

The MAGIC evaluation findings are based on the following activities:

### *Development of a programme logic model*

Informed by a 'theory of change' approach, OPM worked closely with the MAGIC core design team to develop an overarching theoretical logic model that explains the drivers that influence the programme, the programme's main activities, the mechanisms that enable the activities to contribute towards improvement, and the programme's intended impacts and outcomes. The model is presented in Figure 1, overleaf.

### *Observation at MAGIC local design team (LDT) and core design team (CDT) meetings*

The evaluation team attended the majority of the LDT and CDT meetings. We analysed the evaluation team's notes and minutes circulated by the MAGIC team.

### *In-depth interviews with MAGIC participants and stakeholders*

In total, 57 in-depth interviews were completed with clinicians, managers and board members involved in implementing SDM across primary and secondary care settings over two waves of fieldwork (37 interviews during wave 1, 20 during wave 2).

### *Interviews with patient representatives*

We undertook two interviews with members of one of the two PPI panels involved in the MAGIC programme. The purpose of these interviews was to explore how the PPI panels had worked and their role in implementing SDM.

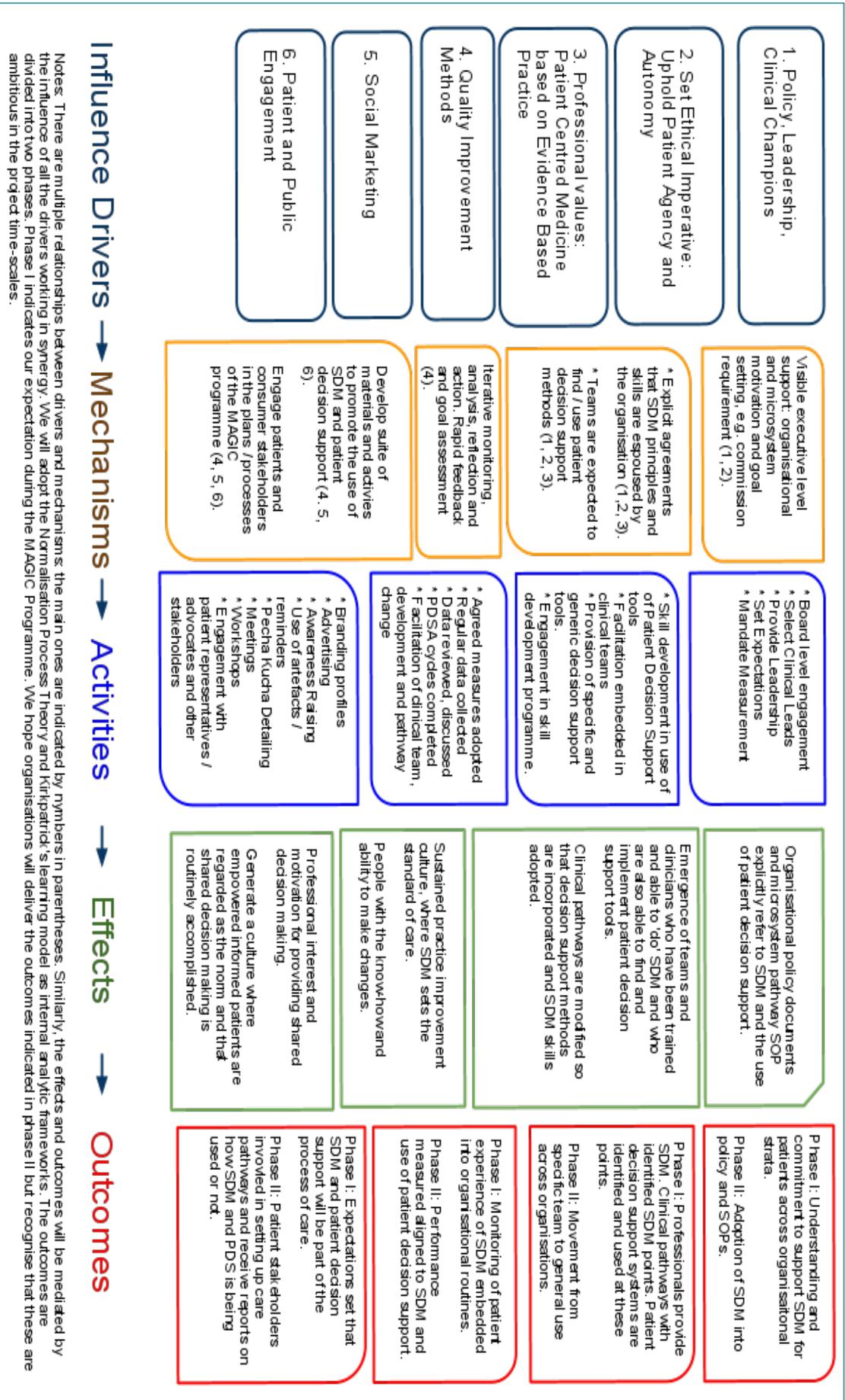
### *Improvement stories*

Interviews were undertaken as part of seven 'improvement story' case studies (27 in-depth interviews with clinicians and 21 short interviews with patients).

The sites for the improvement stories were selected on a voluntary opt-in basis, making it difficult for us to pre-define the sample for the sites. However, efforts were made to ensure as much as possible that we would cover a broad spectrum of clinical teams, including those from a range of primary and secondary care settings. In each site, we interviewed clinicians identified by the core and delivery teams as being central to the implementation process. Patients were selected by the sites or using convenience sampling techniques, where patients were asked to take part in the research when they were attending consultations at the clinical sites. Data and analysis from these has been used to inform this report. We have drawn on evidence from the improvement stories throughout this evaluation.

The improvement stories are published in the Health Foundation learning report *Implementing shared decision making* ([www.health.org.uk/publications/implementing-shared-decision-making](http://www.health.org.uk/publications/implementing-shared-decision-making)).

**Figure 1: The MAGIC programme logic model**



## *Staff survey*

The MAGIC survey was designed to capture the views and experience of all staff in the participating clinical teams across the primary and secondary care settings in Newcastle and Cardiff.

The survey was completed by 59 clinicians, with 40 responses from Newcastle and 19 from Cardiff. This equates to a response rate of 23% and 19% respectively, giving an overall response rate of 22%. As all completions were via the online survey, all of the closed questions were able to be 'forced', which guaranteed that all participants provided answers.

## **Data analysis**

This report draws on both qualitative and quantitative analysis:

### *Qualitative analysis*

Qualitative data collected as part of the evaluation were analysed using 'Framework', a content analysis method developed at the National Centre for Social Research (NatCen). This approach involves the systematic analysis of verbatim material within a thematic matrix. Project documentation was also captured in the above frameworks. The matrix was informed by the areas covered in the theory of change models and by other key topics and issues emerging from the data. Data from each stage of the study were mapped within a different – although linked – set of thematic charts. These then formed the basis for detailed exploration of the charted data, covering the range of views and experiences of MAGIC, comparing and contrasting individuals and 'groups' and seeking explanations for similarities and differences within the data, and exploring the extent to which the hypotheses outlined in the logic model had been realised.

### *Quantitative analysis*

The survey results were subjected to basic descriptive statistical analysis of the overall results, with some exploration of differences between sub-groups (for example, between primary care and secondary care and between Newcastle and Cardiff). While the data provided valuable feedback on the impact of the MAGIC programme, the small sample size, particularly when disaggregated to particular teams or geographic sites (Cardiff/Newcastle) did not allow for statistical significance testing. For open-ended data, OPM conducted a thematic analysis of the responses and produced a series of tables highlighting the frequency of different themes. These data were incorporated into the evaluation analysis process.

Quantitative data were collected using decision quality measure (DQM) questionnaires and shared decision making questionnaires (SDMQ). While they have potential to track what impact the MAGIC programme was having on how decisions were being made, not all teams were confident about the reliability of data at the time of the evaluation. For example, in some local teams, changes had been made to the wording used in Option Grids, and they felt that it would be difficult to disentangle the impact of this from the impact of shared decision making more generally. DQM and SDQM data were being collected by local teams on an ongoing basis at the time of the evaluation, and should provide valuable insights into the subsequent impact of the MAGIC programme.

## **Limitations of this evaluation**

This evaluation was informed by a range of perspectives from clinicians involved in implementing MAGIC programme activities. As we indicate above, we spoke to a range of

stakeholders at a number of different stages of the programme, and in the final stages of the evaluation, undertook in-depth exploration of implementation in specific settings to prepare the improvement stories. However, it is important that we are clear about some limitations in terms of what the data can tell us.

One limitation concerns patient perspectives. While our planned approach initially involved a strong focus on patient perspectives, stakeholders in the programme expressed concerns about the burden of recruitment and facilitation on the clinical teams, and ultimately, the decision was made not to include these. While we were able to include some patient perspectives in the improvement stories, these individuals were recruited via convenience sampling. The interviews with patients were also relatively short in length, and so did not facilitate in-depth exploration of patient experience. We cannot therefore be confident that we have heard a sufficiently diverse range of patient perspectives and experiences of SDM as part of the MAGIC programme to draw any firm conclusions.

A second limitation concerns the nature of the survey data collected. Partly in order to address the gaps in data on the patient experience, our survey asked clinicians who had taken part in MAGIC training to 'self-report' on some issues, including the degree to which SDM has informed their practice and patients' experiences. It is important to be clear that these perspectives belong to clinicians, and we do not, of course, know if they were shared by patients.

Finally, it is helpful to be clear that we do not have sufficient evidence to make comparative evaluations of the different teams. This was not an aim of our evaluation, and so we did not collect data that would facilitate a detailed and robust comparison.

## **Extent of change**

As mentioned in the Introduction, we developed a programme logic model which set out a number of high-level 'effects' that the programme sought to realise. We have assessed the extent to which these occurred as a result of the programme using evidence generated through this evaluation.

## **The structure of this report**

This report presents the findings of the evaluation of the Health Foundation's MAGIC programme, based on the approach and data outlined in the previous section. It is structured as follows:

**Section 2** describes the starting position of teams, against which we track the extent of change later in the report.

**Section 3** explores the implementation processes and learning, structured around six key activities within the MAGIC programme: changing professional attitudes; building clinicians' skills and confidence; raising patients' awareness and changing their expectations; integrating SDM into the existing health system; restructuring clinician/patient interactions in new ways; and embedding SDM in healthcare settings.

**Section 4** outlines our conclusions.

### *Terminology*

Throughout this report, we refer to people we interviewed as *evaluation participants*. We use the term *clinicians* to encompass doctors and nurses, to reflect the role that nurse practitioners played for patients with some conditions. We use the terms *clinical pathways* or

*care pathways* to describe patient journeys through the entire healthcare service from first contact and referral, through to diagnostics, testing and consultation and the completion of their treatment.

Throughout the report, we refer to shared decision making by its abbreviation (SDM). This is not to suggest that SDM is a particular model or prescription. The term SDM is used as a shorthand to capture the range of tools, behaviours and outcomes associated with the broad objective of achieving shared decision making between patients and clinicians.

Throughout this report we also refer to SDM tools. These are tools that provide facts about a specific healthcare condition, the options for treatment or screening and their outcomes, and risks and probabilities. The main types of shared decision tools mentioned in this report are brief in-consultation decision support materials, such as BDAs and Option Grids.

See also the Health Foundation learning report, *Implementing shared decision making* ([www.health.org.uk/publications/implementing-shared-decision-making](http://www.health.org.uk/publications/implementing-shared-decision-making)). This contains the seven improvement stories that describe in more depth the role played by some of the clinical teams involved in the MAGIC programme.

## 2. The starting position of clinical teams

This section of the report sets out the starting position of clinical teams prior to becoming fully engaged in the MAGIC programme. In constructing this assessment, we have drawn upon a mix of qualitative interviews with clinicians based in clinical teams, documents supplied by clinical teams, and MAGIC programme reports to the Health Foundation. Specifically, we looked at the position of teams entering the programme in relation to the following dimensions:

- attitudes, knowledge and awareness of shared decision making (SDM)
- readiness of teams to engage in SDM
- practical experience of using SDM tools, such as decision aids
- clinical pathways and systems.

### 2.1 Awareness of, and attitudes towards, SDM

Before engaging with the MAGIC programme, evaluation participants generally reported being familiar with the concept of SDM and could articulate its main defining features – that is, the belief that clinicians should explain care options to patients, should take decisions jointly with patients, and encourage patients to take control over their own care.

*SDM is about giving the patient the opportunity to be involved as much as they possibly can, or as much as they want to be, in any decision about their care. (Doctor)*

Participants across the clinical teams reported having little previous training on SDM, either as part of their clinical training or continuous professional development. It was unusual for clinicians to have hands-on experience of using or implementing SDM tools such as decision aids.

Evaluation participants generally believed that SDM would benefit patients. More exceptionally, they felt that more evidence would be needed if a larger number of clinicians were to be persuaded to adopt SDM – particularly robust evidence of the impact of SDM on improved clinical outcomes.

Although direct experience of utilising formal SDM tools was limited, many participants believed that they already use aspects of SDM in their everyday practice, albeit informally. For example, some participants described how, as part of information giving, clinicians had, over recent years, spent more time explaining information and care options and clarifying the patient's level of understanding of this.

*While not all individuals in our team practice what you could describe as structured SDM, we do, on the whole, adopt many facets of an SDM approach – ie, we provide patients with an overview of options and go through information in more depth. (Doctor)*

Prior to the programme commencing, attitudes towards SDM were reported to vary across different staff groups. Some evaluation participants reported being concerned by the resistance to SDM shown by some groups, including senior clinicians, long-standing and experienced GPs, and some middle managers; although they acknowledged that there were, of course, exceptions to this rule. Nursing staff and newly qualified consultants, on the other hand, were generally felt to be more interested in engaging with the concept of SDM.

In terms of commitment of senior managers, there was a mixed picture. Both the Newcastle and Cardiff sites benefited from having a small number of committed managers, but

generally, most senior managers were reported to have little knowledge of SDM or prior commitment to it.

Participants were keen to take up opportunities to learn about SDM and advance their skills. They were generally able to clearly envisage the benefits it would bring for patients and felt they had a potential role in helping to realise those benefits. In some cases, clinical teams felt that there was a specific rationale for them to try to implement SDM. For example, the obstetrics team in Newcastle initially identified vaginal birth after caesarean section (VBAC) compared with elective repeat caesarean section. The team were keen to develop an SDM information pack to support women to draw on the existing evidence about the risks and benefits of each option in order to fully explore their preferences and priorities.

More exceptionally, staff groups such as receptionists and administrators could not immediately envisage what their role would be in making SDM happen.

## 2.2 Readiness of teams to engage in SDM

The clinical teams generally included a small number of people with the knowledge and commitment necessary to champion SDM. However, teams still tended not to feel fully prepared to engage with the programme. Many were concerned by the degree of change needed in the way that clinicians and staff engage with patients; other key concerns reported included a lack of capacity, lack of experience of practising SDM, and little infrastructure to support the use of SDM tools, such as IT systems and facilities.

The degree to which team members had a shared understanding of what they wanted to achieve through the programme also varied. Some teams had a strong sense of which aspects of SDM they wanted to develop, or the conditions they wanted to test SDM practices on, but in other teams, the plans were far from agreed.

Some clinical teams – such as the breast cancer team in Cardiff, for instance – were already using a decision aid and therefore had a strong foundation of understanding on which to build, whereas other teams had no prior experience of implementing formal SDM tools.

## 2.3 Practical experience of using SDM tools such as decision aids

At the start of the programme, few participants reported having either received specific training or skills development on SDM or having first-hand experience of using SDM tools such as decision aids.

In some cases, such as the breast care team and the head and neck team in Cardiff, some clinicians were already using decision aids, but the use of the tools was not adopted by all staff. While there was a high level of interest in the use of SDM, high staff turnover, scepticism and resistance from some senior clinicians, and restrictions on the amount of time clinicians spend with patients had, in the past, prevented the wholesale adoption of SDM tools.

In primary care, there was a limited track record of teams using standardised SDM tools or processes. While some GPs and practice nurses felt that they adopted SDM principles in their everyday encounters with patients (such as active listening and information giving), this was not formally structured. Participants hoped that the MAGIC programme would help to address this:

*We have no formal approach and we need time and a 'team' to help provide this. (GP)*

## 2.4 Care pathways and systems

It was exceptional for clinical teams to have started the process of redesigning care pathways or wider systems to support the embedding of SDM prior to the MAGIC programme’s involvement. One team reported that clinicians had introduced a new step in the care pathway to allow patients to discuss test results in detail with nursing staff prior to having a fuller consultation with the consultant. However, this was a fairly isolated example. Most teams acknowledged that there would need to be significant changes to implement SDM, not only to care pathway design, but also to the systems and processes that support the development of integrated care such as commissioning regimes, targets and incentives.

## 2.5 Patient awareness and involvement

Participants told us at the start of the programme that there was a low level of understanding about SDM among patients. However, they did argue that the push to increase patient satisfaction and involvement within the NHS over the past 15 years had increased patient awareness of their rights more generally. They also felt that patients now consistently received better quality information, but recognised that this is only a small component of SDM. Few of the clinical teams could point to recent experience of engaging patients directly in SDM.

Table 1 below sets out the starting position of the clinical teams involved in the MAGIC programme.

**Table 1: Starting position of clinical teams participating in the MAGIC programme**

Domains	Starting position
Awareness, attitudes and knowledge	<ul style="list-style-type: none"> <li>• Low levels of awareness and in-depth understanding of SDM concepts and principles, but the perception among some that they were already using SDM</li> <li>• Some senior managers committed to implementing SDM, but many were not fully engaged</li> <li>• Participants from across a range of clinical teams in primary and secondary care applying some of the key principles underpinning SDM, such as having detailed discussions about treatment options with patients</li> <li>• Some teams had identified a specific rationale for engaging with SDM</li> <li>• Lack of information and awareness of the available evidence – although limited – of how SDM can improve clinical outcomes</li> <li>• Limited experience of implementing formal and structured approaches to SDM such as using decision aids within the teams</li> <li>• Some key staff groups identified as being resistant to adopting SDM</li> </ul>

Readiness of teams	<ul style="list-style-type: none"> <li>• Teams generally had a small group of committed champions</li> <li>• Teams tended to include some staff who were resistant to engaging with SDM</li> <li>• Limited immediate capacity across all teams to engage in a major programme of change</li> <li>• Existing decision support tools were only available to half of the secondary care teams, and tools were not used routinely in primary care</li> </ul>
Practical experience of SDM	<ul style="list-style-type: none"> <li>• Few teams had previous practical experience of implementing formal and structured elements of SDM</li> <li>• Some teams in secondary care have used SDM tools</li> <li>• Limited use of SDM tools in primary care</li> </ul>
Care pathways and systems	<ul style="list-style-type: none"> <li>• Exceptional examples of teams having started the process of redesigning care pathways</li> <li>• Teams generally had significant needs to change care pathways, targets, systems and other wider organisational processes.</li> </ul>
Patient awareness and engagement	<ul style="list-style-type: none"> <li>• Low levels of patient awareness of SDM</li> <li>• Few examples of engagement of patients in SDM</li> </ul>

## 2.6 MAGIC clinical teams

The focus of activities undertaken by the clinical teams involved in the MAGIC programme is summarised in the Table 2 below.

**Table 2: Focus of activity undertaken by clinical teams participating in the programme**

Clinical setting	Focus
GP practices	<p>The seven primary care settings involved initially focused on decisions about antibiotic prescription and high cholesterol management, and have since widened the range of decisions in which SDM is used.</p> <p>Their work focused on testing the use of generic decision support tools, and activating patients.</p>
Obstetric unit	<p>With an initial focus on decisions about repeat caesarean sections, this multidisciplinary team widened its scope by using generic decision tools for other key obstetric decisions such as prenatal screening, place of birth, and management of breech presentation.</p>

Breast unit	This team focused on implementing SDM for the choice between mastectomy and breast conservation surgery for women with early breast cancer.
Ear, nose and throat department	At the time of the evaluation, the focus of this team's work was on decisions about paediatric tonsillectomy. It has since begun to expand the scope of its work to look at implementing SDM for 'glue ear'.
Urology department	This team focused on decisions about benign prostatic hypertrophy (BPH), the choice between conservative treatment/self-monitoring, drugs and surgery for men with lower urinary tract symptoms. It trialled the use of an NHS information booklet and personal decision form for BPH.

## 3. Implementation processes and learning

### 3.1 Changing professional attitudes

An initial focus of the MAGIC programme was to change professional attitudes and practice and the culture of the health service in a way that facilitates the delivery of shared decision making (SDM). This acknowledged that for SDM to be more widely practised, doctors, nurses and other clinicians need to embrace the idea, and need to be convinced that the advantages to patients outweigh the perceived disadvantages of adapting their traditional work practices.<sup>7</sup>

This section focuses on how the MAGIC programme sought to change professional attitudes to SDM, including how it aimed to demonstrate the benefits of SDM to health professionals (the focus of objective 2). Changing the *practice* of health professionals is addressed in section 3.4. The outcomes that the MAGIC team aimed to achieve from changing professional attitudes were as follows:

- Most, if not all staff, will have become aware of SDM and many will know of the benefits that are achievable in terms of patient experience, cost effectiveness, quality and safety.
- Senior management teams (managerial and clinical) will have committed themselves to supporting the concept of patient involvement in decision making as a fundamental value that underpins the work of the organisation, and will have begun the process of aligning incentives and performance measures accordingly.

#### Activities delivered as part of MAGIC

The MAGIC programme developed and implemented a number of activities to inspire clinicians to get involved. Early engagement activity is outlined below.

#### **The identification by the MAGIC team of enthusiastic clinical champions for SDM, who were willing to take the lead in promoting it in their own clinical settings**

The MAGIC team approached a number of clinical teams to take part in the programme. In some cases, teams were selected on the basis that they included clinicians who were known to have experience of, and commitment to, SDM. For instance, the breast care team in Cardiff had previously worked with the academic team at Cardiff University on the development of SDM tools. Other teams were less well-known to the MAGIC team, and only became engaged with the programme after a process of some exploration of how SDM might be used in their setting and their willingness to engage.

Initially, MAGIC considered developing a maturity index that would allow the programme to substantially assess the readiness of each team to adopt SDM and help to identify what support they required. This tool was not developed, however, largely due to time and capacity pressures.

One of the most important activities undertaken by the MAGIC core design team to build commitment and buy-in was identifying champions with previous knowledge of SDM. Some clinicians were identified based on existing professional relationships and networks. They included clinicians who had taken part in previous SDM projects (including developing

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<sup>7</sup> Coulter A. (2009) *Implementing shared decision making in the UK*. London: The Health Foundation, p 23.

decision aids) as well as those who had studied SDM as part of their formal education or were known to be 'sympathetic' to the ethos and principles associated with SDM.

### **Inviting experienced SDM practitioners and international experts to visit the participating sites and give presentations on the benefits of SDM and practical approaches to delivering it**

Participants in the evaluation felt that having credible and influential champions (from a range of backgrounds, including patient champions) was critical to inspiring a wider set of clinicians to take part in the early stages of the programme, and sustaining their engagement over time.

### **Involving staff in introductory training sessions on SDM, which were made available to participants from all of the clinical teams**

Including basic and advanced sessions, this training sought to introduce clinicians and other participating staff to the theory underpinning SDM and its practical application.

### **Using the plan-do-study-act (PDSA) cycle to understand how to secure engagement of wider teams**

Throughout the programme, the MAGIC team trained and supported staff in how to use the PDSA quality improvement tool as a way of encouraging clinicians to focus on small and incremental changes and learn from the improvement process. This was reported as being helpful to SDM champions in engaging a wider group of staff. For example, the obstetrics team in Newcastle used a PDSA process to explore how reception staff felt about taking responsibility for sending out information leaflets to patients prior to their appointments.

### **Focusing positively on how SDM improves existing good practice**

Evaluation participants reported that a key barrier to clinicians taking part in the MAGIC programme was the perception that they were already making shared decisions with their patients,<sup>8</sup> and so did not see the need to improve their practice. However, some were sceptical about whether colleagues who were reluctant to take part for this reason were indeed delivering SDM. Some participants reported that colleagues who felt they were already using SDM tended to see it as making sure that patients had a good understanding of their health issues and treatment options, but not necessarily involving them in treatment or management decisions.

In the early stage of the programme, the MAGIC team's work to actively challenge this perception through introductory presentations and the advanced training sessions was felt to have been important. The MAGIC core design team were clear in their approach to engagement with clinicians that SDM was about improving and enhancing current good practice, counteracting the 'we are already doing this' response with 'how can we help you do it better?'.  

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*I would say the workshops have been the most important thing in turning people's attitudes from "We do it already" to "Well, I thought we did actually, but now you've shown us that it's not what I thought it was". (MAGIC team)*

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<sup>8</sup> This perception is not unusual. However, evidence suggests that SDM is not widely practised in the UK; patient surveys consistently report high numbers of patients who do not feel consulted. See Coulter A. (2009) *Implementing shared decision making in the UK*. London: The Health Foundation.

Where this perception persisted over time, participants reported that feedback data from patients about their experiences of interactions with individual clinicians (using decision quality measures (DQMs)) had been helpful to highlight areas in which they could personally improve their practice.

### Using a facilitative and differentiated approach

For some programme participants, the invitation to take part in an externally funded, academic-led programme was regarded with suspicion. They were resistant to the idea of having ways of working imposed on their existing practice, particularly where it was not clear what benefits it would add. They were also reluctant to become involved in what some participants initially conceived as a 'research' study. These misgivings were not generally realised as the programme progressed. Evaluation participants felt that the approach used by the MAGIC team had been highly facilitative, building on their existing practice, allowing them to work in a way that felt comfortable to them, and emphasising the potential benefits of involvement.

From the outset, participants felt that the following messages had been important in securing their engagement:

- **Improvement not research:** Early communications about the programme overemphasised the importance of systematic data collection, leading some to believe that MAGIC was more of a research project than a quality improvement, change management initiative. Participants reported having been concerned that they would become drowned in a 'data hungry' research project. The MAGIC team recognised this challenge early in the programme, and changed the language used to describe the project to focus on collaborative improvement rather than research. Feedback from participants who came to the programme later suggests these modifications were successful, with this group pinpointing the language used by the MAGIC team as being one of the factors that helped to secure their commitment.
- **SDM builds on existing skills:** Participants felt that the language used by the MAGIC team also encouraged them to see that SDM, while requiring a new approach, built on the skills and approaches they were already using.

*They were always positive about our existing skills, and tried to show that through a small number of changes in the way we worked, SDM could take place. (Clinician)*

- **Outcomes for patients:** Through the programme's training materials and face-to-face communication with clinical teams, MAGIC facilitators sought to emphasise that SDM was about improving patient outcomes. Using patient perspectives in programme materials and communications also helped to bring clinicians on board.
- **Outcomes for clinicians:** The MAGIC team also used initial engagement opportunities to emphasise the benefits of SDM for clinicians, including the development of new skills, the adoption of good practice, and the benefits that would arise from having more satisfied patients.
- As the programme progressed, the **degree of autonomy for clinical teams** was felt to have been important in maintaining clinicians' commitment. Participants spoke about the importance of the MAGIC team adopting a 'hands-off' and facilitative approach to working with staff, which they felt was markedly different from their experiences of similar projects in the past. While participants recognised the need for a degree of top-down direction and clear aims and objectives, they welcomed the freedom they were given to test new ideas and change tack when necessary. For instance, during skills development workshops

and action learning sessions, participants were encouraged to identify the subject they would like to work on and develop their own project plans.

*We were given a largely free rein to choose what we wanted to work on – I felt that they took the time to observe how we worked and understand our issues first, before rushing in with their own suggestions. (Member of clinical team)*

As part of this process, teams were able to decide where to apply SDM and the approaches and tools they used. Coupled with this, project oversight by the MAGIC team helped to maintain the momentum.

The importance of carefully assessing clinical teams' readiness to engage with SDM and addressing any attitudinal barriers was highlighted by several evaluation participants.

*We should've done more in-depth diagnostic work. I think we didn't do enough attitudinal shift work, so we kind of said, "Are you up for this? Are you excited by this?" But we didn't get people to look at their own attitudes to shared decision making and look at shifting those as an activity itself rather than just saying, "Let's get on and do it". (MAGIC team)*

As mentioned previously, the MAGIC core design team initially considered developing a team maturity index that would allow them to assess the readiness of teams to implement SDM as well as identify the type and level of support they would require. Initially, they decided against creating a formal tool, although they revised this position later and were in the process of developing such a tool at the time of writing this report.

## Extent of achievements

### Engagement

The MAGIC project initiation document (PID) outlines the aspiration that senior management teams (managerial and clinical) will have committed themselves to supporting the concept of patient involvement in decision making as a fundamental value that underpins the work of their organisation.

Looking across the sites where the MAGIC programme was being delivered, all had achieved at least some degree of success in engaging senior champions for SDM in awareness-raising activities. Most senior champions we interviewed told us that they chose to engage with the programme because they had read evidence and understood intuitively that SDM would improve patient outcomes and potentially reduce inefficiencies in the system. They also spoke of wanting to use the training to advance their clinical skills.

The PID also describes an aspiration that most, if not all, of the staff in settings where the programme is being implemented should be aware of SDM and its benefits. The evaluation found that while there were a number of examples of settings where the majority of clinical staff had some engagement with MAGIC, none of the evaluation participants said they had experienced uniformly positive reactions to SDM.

Some senior clinicians, such as hospital consultants and GPs, were reported to be more difficult to engage. Evaluation participants attributed this to a range of factors, including individual personalities, working styles, time pressures (including short consultation times with patients), the degree of professional autonomy they are used to, traditional expectations about the respective roles of clinician and patient, and, in some cases, a resistance to change.

In contrast, there was a view that nursing staff tended to be easier to engage than other clinical staff. The reasons given for this included the view that, in general, nurses spend more

time directly with patients and that they have an education and approach to care-giving that commits them to a collaborative way of working with patients.

*Breast care nurses in this team have always practised SDM and supported patients with information to aid their decision making. (Nurse practitioner)*

However, with such a small sample of nursing and non-nursing staff taking part in this study, it is difficult to be certain about whether this view is supported by evidence.

Considering the starting position described earlier, the evaluation found evidence to suggest that the programme has been successful in increasing the number of staff engaged in programme activities, including senior managers, although pockets of staff within most of the teams remained disengaged despite continuous efforts to get them involved.

*Not for want of trying, there are still at least two GPs in the practice who are still not interested or engaged in the project. (Clinician, Cardiff)*

Those taking part in specific SDM projects within clinical teams largely stayed committed throughout the programme, and most already have plans to continue implementation after the programme ends.

### **Understanding of, and attitude towards, SDM**

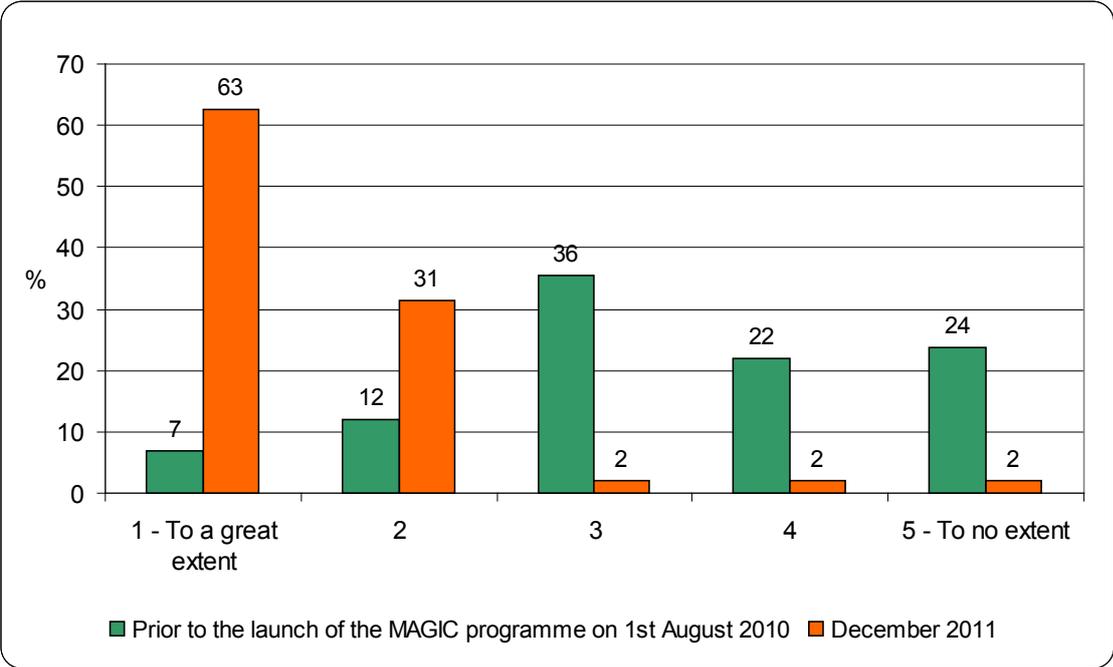
Looking back to the beginning of the MAGIC programme, participants reported that the level of understanding of SDM was relatively low among members of participating clinical teams. While there were some established experts in SDM involved in some of the clinical teams and GP practices, and some had experience of using decision support aids, participants were generally reported as having limited knowledge of what SDM entailed in practice.

Over the course of the evaluation, we have observed a growing understanding among clinicians about the key concepts, principles and approaches that underpin SDM. For example, while only 19% of participants in our survey<sup>9</sup> felt that they had a high level of understanding of the concepts and practice of SDM prior to the MAGIC programme (giving themselves a score of 1 or 2, as shown in Figure 2), this increased to 94% by the time of the survey.

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<sup>9</sup> Participants in the survey were clinicians who had taken part in the MAGIC training.

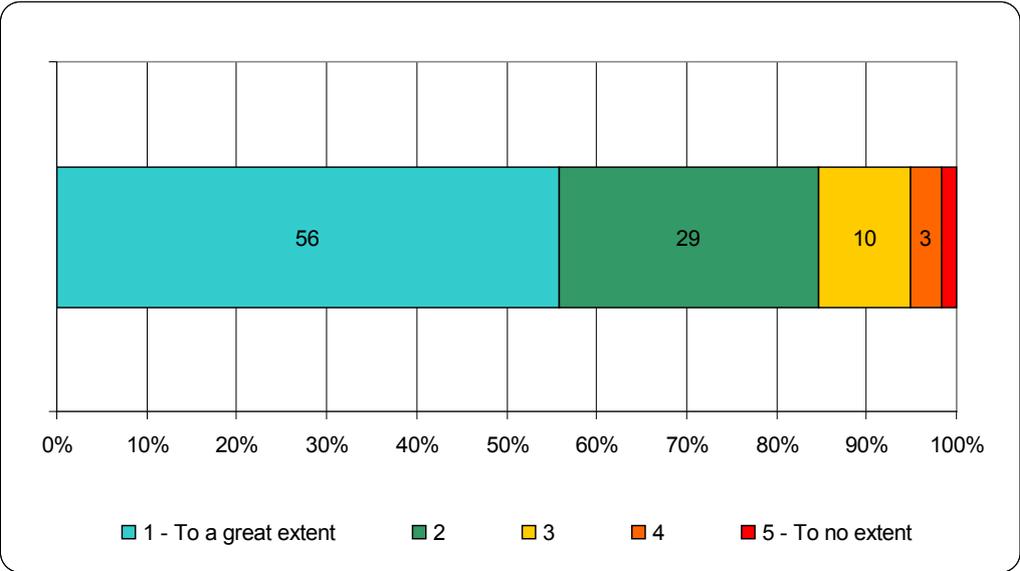
**Figure 2: Extent of understanding of the concepts and practice of SDM**



Base: All (59)

Participants attributed a great deal of this change specifically to the work undertaken by the MAGIC team and to learning generated as part of the implementation of SDM, with 85% saying that their understanding had been developed to a great extent or to some extent as a result of the programme (see Figure 3).

**Figure 3: Extent to which understanding of SDM has developed as a result of team being involved in the MAGIC programme**



Base: All (59)

Our evaluation did not encompass a statistical ‘before and after’ comparison of attitudes and behaviours. However, it was possible to detect a shift in understanding between early and later rounds of qualitative interviews. In the first round of interviews, stakeholders often

reported having a basic understanding of SDM. For instance, they understood that it was about ensuring that patients have a deeper involvement in selecting care options and treatment. In the later interviews, this perception had shifted, with more stakeholders reporting that they not only understood SDM as an important paradigm in care-giving, but that they actually understood how to deliver it *in practice*, as part of their routine approach to providing care.

Existing literature on SDM suggests that even in cases where clinicians have a strong understanding of SDM, this is not always reflected in their clinical practice.<sup>10</sup> The following sections of the report therefore explore the other factors influencing the implementation of SDM.

## Lessons learned

Based on the experience of the MAGIC programme, the evaluation can draw some broad lessons about how best to encourage clinicians to engage with SDM:

- There is a need to constructively challenge some clinicians' perception that they are already delivering SDM. Introductory presentations and training provided by the programme were helpful in challenging these often deep-rooted perceptions – for example, by demonstrating what good-quality SDM might look like through role play, and using patient feedback about their satisfaction with involvement in decisions to challenge any complacency among clinicians.
- A facilitated and differentiated approach to implementing SDM was important in securing the engagement (and ongoing participation) of clinicians, based on a sound understanding and appraisal of the contexts in which they worked, including the readiness of staff to engage.
- There is a need to present evidence (where it exists) about the benefits of SDM in relevant clinical settings.

With hindsight, several members of the MAGIC core design team told us that they would have benefited if they had had more time to assess and prepare teams, and to carry out a systematic assessment of their readiness. For instance, because of staff shortages, one team told us that they did not feel ready to engage with the programme when they were asked to take part:

*Introducing this project at a time when our team was radically reduced has put a huge amount of pressure on us and therefore has not been especially welcomed.* (Primary care practice manager)

Evaluation participants described a range of different dimensions that might influence how well teams are likely to work together to implement SDM. We have attempted to capture these in a readiness assessment tool (see box overleaf).

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<sup>10</sup> The Health Foundation (2012) *Helping people share decision making*. London: The Health Foundation.

## Readiness assessment tool

<b>Factor</b>	<b>Readiness assessment</b>
Clinical lead in place but also system leader, day-to-day leader, technical leader	XXXX
Clarity of goals and expectations across the team	XXXX
Strong commitment by senior leadership	XXXX
Support from middle management	XXXX
Team has pre-existing knowledge of SDM	XXXX
Decision support materials exist for the clinical setting/specific conditions	XXXX
Staff capacity exists to manage implementation, including taking part in quality improvement exercises	XXXX
Quality of IT support systems (including location of printers, practice/department software, waiting room and consultant room facilities)	XXXX
Targets in place align with SDM goals	XXXX
Quality of existing patient engagement processes	XXXX
Experience of using quality improvement methodologies	XXXX

## 3.2 Building clinicians' skills and confidence

A second focus of the MAGIC programme was to help teams and patients build the skills and confidence they need to do more and better SDM consultations. This was borne out of recognition that the development of skills for delivering SDM was as, if not more important than having decision support tools.

This section explores how the MAGIC programme sought to help teams develop their skills to implement SDM. The development of patients' skills is explored in section 3.3.

### Activities delivered as part of MAGIC

The MAGIC skills development programme was offered to all participating staff and was one of the main methods of engaging them in programme activities. This included:

- an introduction to SDM, which presented the high-level concepts and practice of SDM, aimed at all participating staff
- the extended skills workshop/advanced SDM skills workshops, aimed at clinicians who were likely to be implementing SDM
- action learning sets for staff in primary care settings.

#### Advanced SDM skills workshop

The advanced SDM skills workshop:

- explored how SDM can benefit the clinician and the patient
- built up clinicians' skills needed for this approach
- gave participants the opportunity to reflect on their own style of patient/clinician interaction
- introduced participants to specific skills that can help them do SDM better.

Following early experiences of delivering the training, the MAGIC team made a number of changes to improve the sessions and boost levels of attendance, particularly by senior clinicians. The main changes involved:

- adjusting the content to ensure that it better met the needs of specific clinical staff groups
- making sessions shorter, particularly to accommodate staff in secondary care
- placing greater emphasis on practical work, including testing real decision support materials.

For clinicians, participating in the training often led them to challenge their personal assumptions that they were already delivering SDM. They described having 'light-bulb moments' about the potential to develop their own practice, which contributed to a greater willingness to engage with the programme. This was especially true when participants were involved in role play or had opportunities to hear patient experiences, enabling them to make the connections between theory and routine clinical practice.

Participants identified the role play exercises as a particularly powerful tool in helping them to realise that their practice could be improved:

*When we had the role play exercise I found myself actually coercing the patient into making the decision that I thought was best. Now I'm a lot better at letting people make their own decisions. (Practice nurse)*

### Primary care action learning sets

Training provided by MAGIC was not limited to one-off or follow-up training sessions, but included an ongoing menu of development opportunities, with action learning sets in primary care settings and peer support provided by dedicated local facilitators.

Action learning sets were established to facilitate the implementation process and support continuing motivation and engagement of the teams. As part of the action learning sets, practice team members were introduced to quality improvement (QI) methodologies as a way to structure and focus improvement activities. The learning set agenda focused on the first five steps of the improvement work:<sup>11</sup> forming the team; setting aims; establishing measures; selecting changes; and testing changes. After a short presentation on QI, the team worked together to complete a short table, an example of which is shown in Figure 4 below.

**Figure 4: Quality improvement plan**

	<b>The practice of health</b>
<b>Forming the team</b>	<ul style="list-style-type: none"> <li>Leadership - Nurse practitioner (ideas, motivate)</li> <li>Technical expertise - Practice manager – IT and computer systems</li> <li>- GP &amp; Nurse practitioner (clinical)</li> <li>Day-to-day leadership - Practice manager and deputy manager</li> </ul>
<b>Set aims</b>	Reduce re-consultation rates for coughs/colds/sore throats for children
<b>Establish measures</b>	<ul style="list-style-type: none"> <li>Measure re-consultation rates for same clinical episode (audit Read Code)</li> <li>Percentage of children who have had the booklet who come in over the next four months with the same symptoms</li> <li>Measure the length of consultations when clinicians use the booklet</li> <li>Measure the number of booklets given out</li> </ul>
<b>Select changes</b>	<ul style="list-style-type: none"> <li>We will create a template for recording consultations for children presenting with coughs, colds and sore throats (provide tools).</li> <li>We will train all clinicians in the practice to use the template and booklet (raise clinician awareness)</li> <li>We will use a DVD in the waiting room explaining the booklet (raise patient awareness)</li> </ul>

<sup>11</sup> Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. (2009) *The Improvement Guide: A practical approach to enhancing organizational performance* (2nd edition). San Francisco: Jossey-Bass Publishers.

<b>Test changes</b>	<p>One doctor and one nurse will start using the template to establish its usability in real consultations</p> <p>We will create a training session and, following this, test the number of clinicians who know about the template and booklet, how to access them and when to use them</p> <p>We will run the DVD in the waiting room for one morning and ask patients and receptionists for feedback</p>
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Staff interviewed as part of the improvement stories felt that the action learning sets provided the most useful approach to transferring skills compared with MAGIC’s other training offers, including advanced skills workshops – a finding that is reflected in the online survey of clinical teams, with 90% of participants agreeing or strongly agreeing with this statement: *‘The action learning sets helped me to understand how can I practise SDM in my specific setting’*.<sup>12</sup>

Reflecting on how SDM could be further embedded in their settings, participants highlighted the importance of having ongoing protected space and time where they could develop their practice.

Clinicians talked about the need to shift from the position of supporting the broad values and principles of SDM to one where they were able to integrate specific patient decision aids into their consultations. Clinicians pointed to the value of protected time and group sessions, which allowed them to rehearse different scenarios, use patient decision aids and get critical reflection from their peers. To aid the adoption of SDM techniques, some argued that video review would also be a powerful improvement tool. As well as developing their own practice there was also a keenness to observe consultations led by colleagues who have managed to successfully use patient decision aids in their settings.

## Extent of achievements

### Attendance

The MAGIC programme was successful in delivering the training and skills development activities anticipated in early project planning. The training was largely very well attended. However, evaluation participants did report that some clinicians in the teams testing the implementation of SDM did not attend any of the training. While with any professional training, there are likely to be individuals who are unable to attend for a variety of reasons, participants in the evaluation reported that there were some clinicians who chose not to attend the MAGIC training because of limited interest in, or commitment to, learning more about SDM. This means that in each of the clinical teams in which SDM was implemented, there were likely to be individuals who did not have a shared understanding of what the MAGIC programme was seeking to achieve.

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<sup>12</sup> These percentages are based on a sample of 14 (out of a possible 59) participants who had participated in the primary care action learning sets.

## Effectiveness

### *Understanding of SDM and its benefits*

The survey evidence suggests that the training was broadly successful in engaging clinicians who participated in it (or cementing their commitment to it), influencing their attitudes to and understanding of SDM, and beliefs about whether it could benefit them professionally. Of the clinicians who had taken part in the advanced MAGIC training and responded to the survey, 38% agreed strongly and a further 55% agreed that the training *'has helped me to better understand the concepts and theory behind SDM'*. Figures were broadly similar for participants in the introductory training, though perhaps unsurprisingly, the proportion reporting a high level of confidence was lower for those giving feedback on the introductory skills sessions.

Of clinicians in the advanced skills training, 93% agreed or strongly agreed that the training had helped them to explain to others what SDM is and why it is good clinical practice. A similar proportion of participants in the introductory training agreed with this statement, though a smaller proportion overall strongly agreed, probably reflecting the less detailed nature of this training event. Similar proportions of survey participants were positive about the understanding of SDM they had developed as part of the training.

The MAGIC training was also effective in convincing participants that using SDM could benefit their professional practice. Replicating the pattern described above, participants in the advanced training were more likely to strongly agree it had positively challenged their practice (43%) compared to those who had taken part in the introductory training only (18%).

### *Skills for implementing SDM*

For clinicians who had completed the advanced training, this had a marked effect on their understanding of how they might implement SDM, with 36% strongly agreeing and 57% agreeing that the training *'has helped me understand how I can practise SDM in my specific setting'*. While a smaller proportion of participants in the introductory training strongly agreed with the same statement, a significant proportion – 69% – agreed that the training had helped them to understand how they can practise SDM in their specific setting.

As with training, primary care participants were generally very positive about their experience of action learning sets: 43% strongly agreed and 43% agreed that the learning set had helped them to understand how they could practise SDM in their specific settings; while 36% strongly agreed and 50% agreed that the action learning sets had helped them to explain to others what SDM is and why it is good clinical practice.

### *Impact of training*

This understanding of how to implement SDM broadly translated into changes in participants' day-to-day practice across primary and secondary care. For example, 33% of participants in the extended skills training strongly agreed and 57% agreed that the training had influenced their day-to-day practice. Again, while the effects of training were less pronounced for participants who had only completed the introductory training, 75% still indicated that it had influenced their practice.

Of course, the extent of change in clinicians' decision making practice was influenced by how effectively the skills and lessons covered by the MAGIC training could be translated into day-to-day practice. This is covered in section 3.4, which looks at the integration of SDM into existing health systems, and section 3.5, which explores how clinician/patient interactions were restructured in new ways.

## Lessons learned

The evaluation identified a number of lessons about building clinicians' skills and confidence arising from the MAGIC programme, as follows.

- Advanced skills training for clinicians delivering SDM is critical in helping clinicians to understand the theory and concepts that underpin SDM, and giving them the practical consultation skills they need to make SDM a reality.
- Using improvement methodologies such as action learning sets gives clinicians the time and space to think about how they can implement SDM in their own clinical settings and plan how to do this.
- It is important to tailor learning materials and content to reflect the specific clinical areas that participants work in.
- Participation in training should be mandatory (or is at least strongly advised) for all members of the teams involved.
- Feeding in the patient experience of SDM at every available opportunity (eg, by using patient case studies) enables clinicians to understand patients' perspectives and the benefits SDM can bring them.

### 3.3 Raising patients' awareness and changing their expectations

The third focus of the MAGIC programme was to raise patients' awareness of SDM and change their expectations about how they might share decisions with their clinicians. SDM relies on the active engagement of clinicians and patients with the process so that it is informed by both perspectives or 'sources of expertise'.<sup>13</sup> However, patients may not expect to play, or feel confident playing, the role that is envisaged for them to make SDM happen.

As the Health Foundation's recent evidence review notes,<sup>14</sup> initiatives that focus on 'passive' information-giving to patients are less likely to be effective than those which seek to actively engage patients with SDM. Raising awareness and changing expectations (described by some participants in the evaluation as the 'activation' of patients) was therefore a critical focus of the MAGIC programme.

Wider evidence suggests that having been offered SDM, some patients may not wish to or may not find it easy to take part. Research suggests that there are a range of factors which influence patients' apparent readiness to engage with SDM, including their attitudes, opinions, emotional readiness and life experience.<sup>15</sup> Likewise, there are a number of demographic characteristics, such as age and socio-economic status, which may influence the extent to which people want to share the responsibility for making decisions about their health.<sup>16</sup>

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<sup>13</sup> Coulter A, Collins A. (2011) *Making shared decision-making a reality: No decision about me, without me*, London: The King's Fund.

<sup>14</sup> The Health Foundation (2012) *Helping people share decision making*. London: The Health Foundation.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

## Activities delivered as part of MAGIC

The main way the MAGIC programme sought to raise patients' awareness and change their expectations was through the Ask 3 Questions marketing campaign. This was intended to 'activate' patients prior to consultations. It was anticipated that patient expectations would then be reinforced by effective patient/clinician interaction during the consultations. However, the MAGIC core design team were clear that it would be important to elicit the views of patients in the overall project design, and in particular on activity directed at engaging and supporting patients to actively participate in SDM. Below, we describe how they did this, before moving on to consider the programme's efforts to 'activate' patients.

### **Involvement of patient representatives in implementation of SDM**

Patient representatives were involved in the MAGIC programme via patient and public involvement (PPI) panels to ensure that patient perspectives were reflected in the design of marketing materials, decision support aids, and survey instruments. For example, patient representatives were also involved in the development of a range of materials used in the programme, as part of the Ask 3 Questions campaign and in the development of Option Grids and BDAs. Patient representatives were also involved in ongoing decisions about the strategic direction of the MAGIC programme, attending local design team meetings on a regular basis. Participants felt that this involvement had resulted in the development of more 'patient-friendly' materials, with less jargon.

While evaluation participants felt that patient representatives had been effectively engaged in some tasks and by some teams, other aspects of patient engagement were felt to have worked less well. Teams sometimes struggled to retain members of PPI panels for the lifetime of the project. A range of reasons for this were identified, including high levels of dropout rates for meetings with patients and patients' lack of interest in the subject; also, some patients did not find the sessions sufficiently engaging. At times, this hindered the ability to meaningfully involve patients in important decisions or to make contributions to the programme – for instance, in helping the MAGIC team to design survey instruments or marketing materials.

Participants also expressed the concern that patient representatives involved in the programme to date were not representative of patient populations with diverse attitudes, abilities and needs, and were not always in the position to offer appropriate input to the design of condition-specific Option Grids, for example. Participants also felt that teams had not always drawn on patient perspectives as effectively as they could have – for example, in some instances, patients had been asked to comment on materials or tools, but had not been invited to participate in their development.

For PPI panel members, satisfaction with the nature and extent of their involvement appeared to be related in part to their appetite for involvement. Members with a strong interest in being involved had sometimes been disappointed by the nature and level of involvement and expressed a preference to be more actively involved with the programme.

Engaging patients in the implementation of SDM was identified as an area in which more work was needed in the future. For instance, participants suggested that more could be done to use social marketing and other online processes to engage patients and that patients could be involved in co-designing materials and care pathways in collaboration with clinicians. Another suggestion was to use the policy frameworks of the Big Society and localism to create a cadre of volunteers who would campaign for SDM, train patients, and signpost patients to information.

## Raising awareness of SDM

### *Key concepts, definitions and language*

The MAGIC programme sought to develop a language for SDM that was patient-centred. The starting point for the development of the concepts and language was: 'what does SDM mean for patients?' MAGIC sought to test out its emerging materials with patients to elicit their perspectives on what language was appropriate.

The MAGIC team developed a simple explanation and language for SDM, involving patients in discussion groups to hear their ideas about language, meanings and communication strategies. SDM was felt to be about helping patients understand their health choices and supporting them in making the 'right' decisions. The MAGIC team tested this language on patients and clinicians, developing a simple set of explanations, some of which are set out in the information flyer presented in Figure 5.

**Figure 5: Text for information flyer produced by the MAGIC programme**

#### **Who decides about your healthcare?**

There is often more than one way to improve or treat health problems. We want to help you to understand your choices, and support you to make better decisions about your healthcare.

#### **What is shared decision making?**

Shared decision making is a process where you can expect:

- Support to understand the choices available.
- That your clinician will understand what is important to you.
- That your clinical team will work with you to decide which treatment option is best for you.

### *Ask 3 Questions*

MAGIC developed and managed a specific marketing campaign called Ask 3 Questions to raise awareness among patients about their role in SDM and encourage them to ask three key questions about their health and healthcare options. These three questions were chosen based on existing evidence which showed their efficacy in improving the quality of information about therapeutic options and their benefits and risks.<sup>17</sup> The MAGIC teams developed a suite of Ask 3 Questions materials, including flyers, handouts, pens, posters and materials. These were piloted by a number of the clinical teams.

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<sup>17</sup> Shepherd HL, *et al.* Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. *Patient Educ Couns* (2011), doi:10.1016/j.pec.2011.07.022

Figure 6: Ask 3 Questions poster



Reactions from evaluation participants to the Ask 3 Questions campaign were generally very positive. Clinical teams displayed posters, leaflets and other publicity materials in prominent positions in their settings to help raise awareness among patients that SDM was being applied in their setting and to help them to understand what it entailed.

In addition, clinicians told us of the importance of using audio and visual techniques to raise awareness, arguing that written materials alone are insufficient. This was in recognition of the perception that some patients struggled to relate to written materials and preferred visual stimuli. Responding to these arguments, MAGIC developed a DVD explaining what shared decision making is that could be played on home computers or in waiting rooms. These have been relatively well received, with 20% of survey participants saying that SDM-related films/DVDs had been extremely important/valuable and 34% feeling that they had been somewhat important/valuable. In addition, 64% of survey respondents said that MAGIC posters (including posters explaining what SDM is and the Ask 3 Questions campaign) had been extremely or somewhat important/valuable in helping to implement SDM in their settings. Indeed, clinicians who were not participating in the programme asked if they could use Ask 3 Questions materials in their settings, to encourage patients to participate in SDM.

*... teams are now coming to us, going "When can we have these, can you print them, can you please send them to our clinic?" So they're deciding themselves. (MAGIC core design team member)*

Clinicians in both primary and secondary care felt that Ask 3 Questions materials were helpful in raising patients' awareness that SDM was being delivered in the setting and explaining to them what it meant. However, having the space to display posters and leaflets was one issue identified by consultants. For clinical settings that wanted to play the Ask 3 Questions video, securing space where they could do this without the sound disturbing others was sometimes challenging. In primary care settings, for example, participants reported having to play the video without any volume, because the sound had been disturbing neighbours in the same building.

## Extent of achievements

Activities delivered as part of the MAGIC programme to raise patients' awareness and change their expectations were consistent with what was planned at the outset.

Given the relatively narrow range of patient perspectives included as part of this evaluation, there is limited evidence from patients to tell us the degree to which their expectations and awareness of SDM has developed as a result of the programme's activities. Based on what patient representatives and individual patients told us, there generally appears to have been a positive response to the key messages of the Ask 3 Questions campaign, for instance, and they could see how it might be helpful in promoting better interactions with clinicians than they may have had in the past:

*I suppose in the past I've just been quite happy to take the doctor's advice. But there have been times when I've come out and thought, "Well, I didn't really want to do that, perhaps I should have asked if I could do it this way," and probably, if I had asked, they would have said, "Yeah, that's fine." So really, I think I just need to be a bit more vocal and say, "Is that the only option or is that the only sensible option open to me?" (Patient)*

However, patients were sometimes uncertain about how they would put SDM into practice. During patient interviews conducted as part of the improvement stories, patients reported that they felt they would engage in SDM if they received the appropriate support and encouragement from clinicians and could see that it could improve their health. They felt that they would need assistance to understand how to make shared decisions as well as direct encouragement from clinicians. Given that clinicians have sometimes needed to see SDM in action (for example, in role play exercises during training sessions) it is perhaps unsurprising that patients also find the concept hard to grasp in the abstract. This raises the question of how SDM can most effectively be brought to life for patients. Receptionists, nursing staff, expert patients or carers were identified as having a potential role in this respect, drawing patients' attention to Ask 3 Questions literature, explaining the reasons for asking the three questions, and helping patients to think about how they might ask them.

As discussed above, clinicians were generally very positive about the messages and format of the Ask 3 Questions campaign, which was, in some cases, felt to act as a potential prompt to patients to ask to share in decisions about their care:

*It is important to give them permission to ask questions. I think that if they can see that the teams, with all the posters up in the waiting rooms, and clinicians are handing out the [Ask] 3 Questions flyer, then it really does indicate to the patient that the team is interested in this patient asking questions. (Nurse)*

However, clinicians had mixed views about the degree to which the campaign had been effective in getting patients to play an active role in encouraging clinicians to share the decision making process with them. Some participants felt that early responses to the campaign had been broadly positive. Other clinicians were less convinced that the campaign

was being translated into changes in patient behaviours. Clinicians reported that they sometimes still struggled to get some patients to participate in SDM. Evaluation participants felt that one reason for this was that patients sometimes struggled to understand the purpose of the three questions:

*We asked quite a few patients about the poster campaign, and most of them did not understand what the three questions were. (Practice manager)*

Another reason was that for some patients, the messages in the campaign were not seen to be immediately appealing. Participants reported that some patients had told them that while they wanted to hear the answers to these questions, they wanted the doctor to give them without their having to ask.

Evaluation participants sometimes felt that the Ask 3 Questions campaign would need to be underpinned by significant additional efforts, particularly targeting those patients who are less ready to engage with SDM. Critically, these included reinforcing the messages of the campaign at the consultation stage, which is discussed further in section 3.5:

*I think that one of the problems is that to explain to a patient about MAGIC and what SDM is, is another consultation in itself. (GP)*

Many evaluation participants felt that there would need to be more action taken in future to 'activate' patients for SDM. In order to achieve this shift, participants called for better quality information to be provided at the service level through leaflets, posters and plasma screens. Some participants believed it will be necessary to launch national initiatives in order to achieve the sort of step change in patient behaviour that is required. One board-level participant took the view that a national SDM initiative could contribute to a fuller and more informed conversation between patients and clinicians.

*We need to remember that to get momentum from patients, they have to be sick all the time or have had a friend or family using the system – so we need to do this on a more national basis. For example, Ask 3 Questions could be a national initiative which helps us to manage patients' expectations in a time of finite resources and where patients understand the value of taking greater responsibility for their health. (Senior management/board member)*

It is difficult to determine the extent to which the resources and capacity expended by the MAGIC programme brought about any significant change in patient awareness. The MAGIC team did work with patient forums in each of the sites to engage patients – for example, asking them to comment on programme materials. However, it was generally felt that while the team were successful in engaging patients on specific topics and materials, they were less successful in raising awareness of SDM with patients more widely.

It is difficult for this evaluation to assess whether, where clinicians reported that patients were less willing to engage in the behaviours outlined in the Ask 3 Questions campaign, this was actually the case. We know that clinicians had mixed views about whether there are patients who lack the confidence and willingness to engage in SDM. While 55% of survey participants agreed or strongly agreed that '*patients can lack the confidence and willingness to engage in SDM*', a similar proportion disagreed with this statement. This may, to some extent, reflect clinicians' different levels of willingness or comfort in exploring – and potentially challenging – an apparent lack of willingness to engage with SDM on the part of some patients. It is possible that those clinicians who are not willing or confident in probing patient reactions to SDM may misinterpret some patient behaviours (such as reticence or deference) as a lack of confidence and willingness to engage.

## Lessons learned

The evaluation identified a number of lessons about how best to engage patients in SDM:

- To ensure meaningful involvement, it is important to involve patients through the duration of a specific project, rather than expecting them to respond to issues in isolation from the wider context.
- Information about SDM needs to be promoted in a range of formats (non-verbal, easy read, and in posters and flyers) and through a range of channels (online, paper-based, audio and visual).
- Additional efforts, including outreach and face-to-face engagement, may be needed to engage patients who are vulnerable or have low health literacy.
- Marketing campaigns can provide clinicians with a useful 'hook' on which to introduce the idea of SDM to patients and there is a clear appetite in some clinical settings to do this. However, marketing alone is unlikely to help patients fully understand what SDM may mean for them and how they can benefit from it. Clinicians need to play a role in making SDM 'real' for patients.
- Clinicians need to take the time to explain information in a face-to-face encounter to build trust and understanding.

## 3.4 Integrating SDM into the existing health system

The fourth focus of the MAGIC programme was to integrate SDM into the existing health system, including clinical patient pathways. From the start of the programme it was recognised that for this to be achieved, the participating teams would need to explore how to overcome key practical barriers to integrating SDM into existing systems, including time and resource constraints.

Evaluation participants anticipated that integrating SDM was likely to be easier in secondary care settings than primary care settings. This was because secondary care pathways require in-depth and longer consultations with patients, and were felt to be more likely to be able to accommodate elements of SDM such as the use of decision support materials and the provision of information to patients pre- and post-treatment. In contrast, participants sometimes felt that because of the nature of primary care, where any given GP has to deal with a multitude of different conditions in a single day, it would be difficult to introduce SDM into existing pathways without greatly expanding the amount of time they have to spend with patients. However, while the primary care teams could not identify a radical solution to this time constraint, they felt that some time could be saved if patients were given introductory information and advice about SDM prior to the consultation. An idea considered in one of the primary care teams, for example, was for practice nurses and reception staff to talk patients through Ask 3 Questions as they entered the waiting room so that they had thought through what they want prior to seeing the GP.

This section focuses on how clinical teams responded to the practical challenges associated with integrating SDM into their settings. The use of decision support materials is discussed in more detail in section 3.5.

## Activities delivered as part of MAGIC

The integration of SDM across the various clinical settings involved different activities in primary and secondary care.

## Integrating SDM in primary care settings

In primary care settings, activities initially focused on testing generic decision tools for specific issues or conditions. As the programme progressed, clinicians started to explore the use of decision tools for a wider range of conditions. Some GP practices also tried to apply SDM principles in their setting more widely – for example, when giving patients a choice between having an appointment with a practice nurse and making an appointment with a doctor. In this example, receptionists helped patients to weigh up pros and cons associated with both choices and make a decision based on what was important to them. At the time of the final wave of evaluation fieldwork, some GP practices were also thinking about whether they might modify patient pathways in the future – for example, by sending information leaflets out in advance to patients with specific issues or illnesses, so that they could come to appointments having thought about decisions they may need to make and thus reduce the need for follow-up appointments.

As anticipated by early MAGIC project documentation, the use of time was a prominent issue for primary care clinicians. In the early stages of their involvement in the programme, participants reported difficulty in finding sufficient time and space to translate the understanding and skills acquired during the MAGIC training into their clinical practice. In particular, clinicians reported wanting more time to practise using decision tools.

The perceived increase in consultation times was also reported as being an issue. GPs reported that it was difficult to accommodate SDM into the 10-minute time slots as it tended to take several minutes longer than the time allotted. For doctors trying to ensure that their practice functioned well, this was a prominent concern. Where doctors believed that the immediate or longer-term benefits of SDM outweighed the time required to deliver it – for example, by reducing the need for repeat appointments – this tended to mitigate their concern.

## Integrating SDM into secondary care settings

In secondary care settings, MAGIC programme activities focused on how to implement SDM using condition-specific decision support materials and how patient pathways could be modified to facilitate effective SDM.

In the clinical settings visited as part of the improvement stories, MAGIC teams were modifying the patient pathways in both formal and informal ways.

### *Formal modification of care pathways*

Clinical teams made explicit modifications to patient pathways in two main ways:

- **The introduction of longer appointment times** to accommodate the use of decision tools and in-depth discussion of options. This approach had been taken in nurse-led settings – for example, in Cardiff's paediatric tonsillectomy department. Some participants suggested that this modification seemed to be easier for these settings, because nurses' schedules were arguably less constrained than doctors' schedules. However, given the small sample size of clinicians we interviewed, this view should be treated with some caution.
- **The re-engineering of patient pathways to accommodate SDM by adding new steps.** Where teams felt that there were benefits from patients thinking about their options prior to an appointment, steps were added to facilitate this. For example, the obstetrics team in Newcastle decided to send an information leaflet out to patients prior to

their appointments. They hoped this would help women to arrive at consultations knowing that they would be offered choices about their care, understanding what these were, and being better prepared to make decisions. Other teams felt that patients would benefit from more time to consider their decisions, but that they should be given this time following consultations. This was the case where clinicians undertook tests or diagnostics during a consultation, which would decide the options available to the patient.

### **Case study: making time for patients to weigh up their options**

The urology clinics in Newcastle have modified their care pathway so that patients not only have more time in consultations to discuss the options available to them, but will then be encouraged to go away and reflect on the options available to them following their appointment:

*When we learnt more about SDM, we wondered if this was an area where maybe we were rushing the patients into a decision because we were, at that time, just immediately writing to the doctor and saying, "The patient has decided to try some form of therapy, could you please prescribe this medication" and we certainly think now that that was the case – that the patients maybe weren't given the time to fully think through what it was that they were basing their decision on and what their values were. (Nurse practitioner)*

Participating in MAGIC has given clinicians the opportunity to explore how best to accommodate time for decision making in their clinical pathway:

*... I think this is what shared decisions allowed us to do, it's given us permission to say "Well, actually, you know, you are clearly not at a stage yet where you have worked out what it is that's most important to you, so why don't we give you a little more time and book you to come back after you've had time to digest this and maybe talk it over with your family?" I think that's been, certainly on a personal level, the biggest thing for me. It's given me permission to actually take more time, rather than trying to get that decision made within one appointment. (Nurse practitioner)*

A nurse then makes a follow-up call to ascertain what decision the patient has made and notifies the patient's GP about this.

Changes to patient pathways required investment of time and other resources such as management time at the outset, but in some cases also required additional and ongoing investment of time by staff. New steps introduced to the patient pathways typically involved identifying patient groups who may need to make specific decisions and giving patients more time to reflect on information about treatment options available to them prior to consultation. This involved additional time resource, generally from receptionists. Participants reported that it was not always easy to secure these time commitments. For example, in the early stages of involvement with MAGIC, the obstetrics team in Newcastle identified that it would be helpful if receptionists could flag women who had had one previous caesarean section and send them an information leaflet prior to their 20-week scan. Despite sensitive exploration of this issue with staff by the lead midwife, securing this investment was an ongoing issue at the time the fieldwork for the improvement stories was being undertaken.

Some participants expressed the concern earlier in the programme that SDM would add more steps into the patient pathway, impacting negatively on staff capacity and creating additional costs. Again, in the obstetrics team in Newcastle, for instance, where they introduced an additional step in the pathway to provide patients with more information prior to treatment, an audit of the impact of this change found that instead of increasing the amount of time consultants spent with the patient, it reduced the amount of time, as patients were better informed about their conditions. In the paediatric tonsillectomy team, consultations

took more time initially, but as involvement in the programme continued, the length of consultations reduced. In other teams, there was a broad sense that consultations using SDM still took longer.<sup>18</sup>

### *Informal modification of care pathways*

Other clinical teams reported that while they had not undertaken formal modification of care pathways, they had ‘tweaked’ pathways to accommodate SDM. For example, the paediatric tonsillectomy team at Cardiff hospital offers parents (and children) two options at the pre-assessment stage: to be listed for a tonsillectomy or for ‘watchful waiting’. Parents are not always aware of the (albeit very low) risk of fatality associated with tonsillectomy operations prior to consultations and so sometimes need time to think about their options, priorities and feelings about risk. Where this is the case, the tonsillectomy team offers the option of parents and children going home to think about these issues, rather than having to make a decision on the spot, and if they want to, to come back to the clinic (without having to make an appointment) and speak to a doctor about the issues in more depth.

## **Extent of achievements**

### **Primary care**

At the time of the evaluation, SDM was being used for a range of different conditions including antibiotic prescription, management of carpal tunnel syndrome, smoking cessation, contraception choices, and benign prostatic hyperplasia. It continued to be championed within these settings. However, participants sometimes felt that engagement with the MAGIC programme and commitment to delivering SDM within these settings was not as consistent as it might be, and that as a result, they were not always confident that SDM was being implemented.

Even SDM enthusiasts acknowledged that implementing SDM takes significant time and effort, which might be difficult to sustain over time without ongoing drivers of improvement. Drivers included additional external evidence on the effectiveness of SDM, patient feedback data collected as part of improvement activity showing that there is room for practice to be developed, performance targets which rewarded the delivery of SDM, and critically, activated patients pushing for clinicians to share decisions with them.

However, this should be viewed in the context of the position at the start of this evaluation, which found that there was no previous experience of using SDM tools and no evidence of clinicians changing care pathways to support SDM.

### **Secondary care**

SDM had been integrated into a range of secondary care settings, including obstetric, ENT, breast care and urology departments. The degree to which this integration had been formalised varied. While SDM had been formally integrated into some patient pathways through the introduction of additional steps, for example, in other cases changes to patient pathways had been more informal, with clinicians tweaking pathways to accommodate SDM on a case-by-case basis – for example, by making discretionary follow-up phone calls, sometimes outside their working day.

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<sup>18</sup> This evaluation did not have an economic component, and so we cannot validate whether any changes in care pathways introduced as a result of the MAGIC programme increased or decreased costs.

While it was more difficult to assess the additional time inputs required by this more informal tweaking of patient pathways, these settings appeared to have had to make less significant investments to accommodate SDM than their counterparts, who had committed to resourcing formal reorganisation of patient pathways.

The extent to which the support delivered as part of these new patient pathways reflected a changing relationship between patients and clinicians is explored in section 3.5. The degree to which new patient pathways were embedded in their settings is explored in section 3.6.

## Lessons learned

- Participants in the MAGIC programme have been willing to invest time in integrating SDM into their everyday practice, largely due to a high degree of interest in and enthusiasm for SDM.
- Within the participating primary care teams, there was a critical mass of doctors willing to accommodate SDM within their practice. Some doctors were confident that the benefits of SDM outweighed any challenges associated with implementation, while others identified a number of potential drivers for/ influencers on their ongoing engagement and practice.

## 3.5 Structuring clinician/patient interactions in new ways

### Activities delivered as part of MAGIC

The fifth focus of the MAGIC programme was to help structure clinician/patient interactions in consultations to facilitate the implementation of SDM. To some extent, the quality of interactions flowed from activities described earlier, including developing clinicians' skills and raising patients' awareness and expectations. However, there are four other ways in which patient/clinician interactions were improved:

- re-emphasising the messages from the Ask 3 Questions campaign
- introducing and embedding decision aids (decision support materials)
- creating a suitable consulting environment for delivering SDM
- putting clinician consultation skills into practice.

### Re-emphasising the messages from the Ask 3 Questions campaign

Some evaluation participants felt that it was important, at the start of consultations, to reinforce the messages of the Ask 3 Questions campaign, either by giving patients a copy of the leaflet and explaining it, or reiterating the messages verbally. In one primary care practice, for example, staff felt that it was important to make copies of the Ask 3 Questions leaflet available in the waiting room, and were experimenting with receptionists handing the leaflet to patients prior to them seeing the GP.

Staff felt that this was particularly important where patients were considered less able to engage in SDM, such as those who lacked confidence when communicating with clinicians or had low levels of health literacy. These views were mirrored in interviews with patients:

*I like the look of the Ask 3 Questions thing, but I would need to be told how to use it by my doctor. (Patient)*

## Introducing and embedding decision aids

Decision aids are an important component of SDM as they provide patients with clear information to help them think about the different care options, help them reach an informed choice,<sup>19</sup> and encourage them to make shared decisions.

Led by a team of experts with previous experience of developing validated decision aids, the MAGIC programme sought to assist clinical teams to develop and test a range of decision aids.

However, the MAGIC team faced a number of challenges in implementing these decision aids, including the following:

- A number of the teams – including most of the primary care teams – had not used decision aids before, and tools are not available for many clinical problems where there are reasonable competing options. When the programme began, existing decision support tools were only available to half of the secondary care teams, and tools were not used routinely in primary care.
- While some of the clinicians had used decision aids before, there was not necessarily a culture and supporting systems in place to make their regular use a realistic prospect. For instance, some clinical teams did not have access to ready-printed supplies of decision support materials and information sheets.
- Some clinicians were concerned about using decision aids per se, regarding them as potentially time-consuming and restrictive, in that overly prescriptive decision tools can be seen to inhibit clinical judgement.
- Developing evidence-based, nationally validated decision support tools is time-consuming and labour intensive.

In cases where pre-existing decision aids were not available, the MAGIC team worked with clinical teams to develop Option Grids or BDAs. These are generally shorter and faster to develop than many other decision aids, which typically present a fuller range of information, are often presented in long booklets or DVDs, and are developed and validated through a national development process.

- Option Grids are based on the questions that patients frequently ask, and are designed for use within clinical encounters.<sup>20</sup> In each grid, brief information about the key features of each option are organised into a table. It is presented so that information about reasonable treatment options can be rapidly compared. Several different Option Grids were developed, including for head and neck cancer, tonsillectomy, glue ear, and breast cancer.
- Brief Decision Aids (BDAs) identify how many options there are and provide some brief detail, including pros and cons, of each one. Simply stated statistical information is included, as well as questions to prompt patients to consider their values and what is important to them in making a decision. There are ten BDAs currently available and more are in development.<sup>21</sup>

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<sup>19</sup> Coulter A, Collins A. (2011) *Making shared decision-making a reality: No decision about me, without me*, London: The King's Fund.

<sup>20</sup> See Option Grid website: <http://www.optiongrid.co.uk/about.php>

<sup>21</sup> See <http://www.patient.co.uk/brief-decision-aids>

The MAGIC team were able to develop these tools collaboratively with the clinical teams and patients, acting as facilitators to help them develop their own tools rather than imposing pre-developed tools without their direct involvement. Participants in the programme reported that this helped to build ownership over the tools, and long-term commitment to their use.

It is important, once these tools have been developed, that they are made accessible to clinicians. In interviews with clinicians based in the Collingwood Surgery, GPs and practice staff described how they made efforts to make decision tools accessible to clinicians. As well as placing them on the practice intranet, each consulting room had a concertina file which held a suite of tools that allowed clinicians to quickly and easily access them during a consultation.

*I think it is helpful to have good decision aids and to have a folder to chip into when you want to look something up or you have that problem in front of you. It's always impossible to do when you can't quite remember where you are going to get access to that information. (Nurse)*

Clinicians identified a range of benefits of using brief in-consultation decision support materials, as described in the box below.

#### **The benefits of using brief in-consultation decision support materials, such as Option Grids and BDAs**

- They are relatively quick and easy to use, especially compared with longer, more traditional decision tools.
- They make the fact that there is a decision to be made very explicit and capture the full range of options a patient has available to them, including in some cases the option of 'doing nothing'. This helps to ensure that patients are clear that they need to contribute to a decision and are aware of all of the options available to them.
- They help to structure consultations, giving them a clear focus and flow, and offering clinicians a set of helpful prompts of what they should cover. This facilitates consistency, both of individual clinicians' practice and across teams. Clinicians felt that it could also make consultations feel 'calmer' – for the clinician and the patient.
- They are a useful reference document that patients (or, if the patient is a child, their parents) can take away from consultations and reflect on their options later.
- They can form a useful basis for discussions about treatment options with spouses or other family members. This is particularly helpful where family members other than the patient have a particular investment in the decisions – for example, where either the symptoms of the health problem (for example, frequent urination at night in the case of patients with an enlarged prostate) or the impact or side effects of treatment affects them and their intimate relationship with the patient (for example, decisions about mastectomies or surgeries where impotence may be a side effect).

Figure 7: Example of an Option Grid



**Tonsillectomy or watchful waiting – for children under 16 years old**

Your child should only be considered for tonsillectomy if:

<ul style="list-style-type: none"> <li>• All attacks of sore throat have been tonsillitis</li> <li>• There have been five or more attacks a year</li> </ul>	<ul style="list-style-type: none"> <li>• They have had attacks of tonsillitis for at least a year</li> <li>• The tonsillitis has led to time off school or difficulties sleeping</li> </ul>
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Frequently asked questions	Tonsillectomy	Active Management
<b>What does it involve?</b>	The tonsils are removed under general anaesthetic.	Appropriate treatment will be arranged by your GP if your child has further episodes of tonsillitis. Your child will be referred for a tonsillectomy if necessary.
<b>How long does it take?</b>	The operation will take about 30 minutes. Your child will need to stay in the hospital for one night.	Until other treatment is considered necessary.
<b>How long does it take to recover?</b>	About two weeks. During this time, your child will need to stay at home to prevent infection.	As with previous episodes, it will take 3-7 days to recover from each event.
<b>Will my child stop having tonsillitis?</b>	Yes, but they may still have episodes of sore throat.	Possibly, 30 out of 100 children will stop having tonsillitis without an operation. They may still have sore throats.
<b>What is the risk from the procedure or process?</b>	As with all operations, there is a risk of serious complications.	There is no real risk to taking this approach.
<b>What is the risk of bleeding?</b>	1 child in every 100 will have serious bleeding immediately after the operation. Most of these will need to have another operation to stop the bleeding.  3 children in every 100 will have serious bleeding in the first two weeks after the operation. Some will need to have another operation to stop the bleeding.	This problem does not occur in this approach.
<b>Will it reduce the number of days missed from school?</b>	Possibly. It depends on how much time your child has been missing from school.	Possibly. As children get older, they often have less attacks of tonsillitis.

Editors: Amy Lloyd, David Owens, Emma Cording, Alun Tomkinson, Valerie Willmott, Graham Roblin, Gareth Williams, Glyn Elwyn  
 Evidence document: <http://www.optiongrid.co.uk/evidence>  
 Creative Commons Licence: Attribution-NonCommercial-NoDerivs 3.0 Unported  
 Last update: 23 January 2012 Next update: Due 22 January 2013  
 ISBN: 978-0-9571887-2-3



Figure 8: Example of a Brief Decision Aid (BDA)

## Carpal Tunnel Syndrome (Pressure on the median nerve in the wrist) Management Options Brief Decision Aid

There are **five** options for the management of carpal tunnel syndrome:

- **Watchful waiting** - seeing how things go with no active treatment.
- **Splinting** - wearing a splint on the wrist which reduces pressure on the nerve.
- **Physiotherapy** - can involve advice on position and working on soft tissues or the nerve.
- **Injection** - of steroid (cortisone) into the wrist to reduce inflammation around the nerve.
- **Surgery** - decompression of (taking the pressure off) the carpal tunnel. This is a hospital operation under local anaesthetic (injection). **In certain situations, such as rapidly worsening symptoms, signs of muscle wasting/weakness or severe functional impairment, your doctor is likely to recommend this option.**

### Benefits and risks of watchful waiting

Treatment Option	Benefits	Risks or Consequences
<b>Watchful waiting - no active treatment</b>	About 35 in 100 people will find their symptoms resolve within six months. This is more likely if you are young (20-29yrs), female or pregnant.  No side-effects or hospital treatment.  You can choose another option any time.	About 70 in 100 people will still have symptoms after six months.  It is already having an impact on your life and well-being.

### Benefits and risks of splinting

Treatment Option	Benefits	Risks or Consequences
<b>Splinting</b> This involves a splint that is strapped to the hand and wrist - sometimes worn just at night and sometimes during the day as well.	Between 50 and 70 in 100 people will have significantly improved symptoms at six months.  It is especially good for night-time symptoms.  Some clinicians can issue these straight away.	Between 30 and 50 in 100 people will not notice much of a difference in their symptoms.  It can be worn during the day though some people may find this a nuisance or restricting.  Sometimes you can only get the splint from a Physiotherapy Department or you might have to buy the splint.

### Benefits and risks of physiotherapy

Treatment Option	Benefits	Risks or Consequences
<b>Physiotherapy</b> This can involve advice on position, working on soft tissues or the nerve.	May help if your symptoms tend to happen during certain activities and if you are found to have nerve or muscle tightness on assessment by a physiotherapist.	This may involve several sessions with the physiotherapist.  There is limited evidence in formal trials of physiotherapy.

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### Benefits and risks of injection

Treatment Option	Benefits	Risks or Consequences
<b>Injection</b> This involves injecting a small dose of steroid (cortisone) into the wrist to reduce inflammation around the nerve.	About 70 in 100 people will find their symptoms settle within 1-2 weeks of the injection.  You may avoid surgery.  The injection can be repeated after an interval of a month or two if necessary.  Particularly useful if symptoms have occurred in pregnancy or if you have had hypothyroidism (low thyroxine level).	About 30 in 100 people will not get improvement following an injection. Less useful if symptoms are very severe, if you are diabetic, or if symptoms have been present for more than a year.  There is a very small risk of damage to the median nerve - this could happen once in every 1000 injections.  Over time, the symptoms recur in about 30-50 in every 100 people after single injection.  The injection is sometimes painful although most people cope with it very well.

### Benefits and risks of surgery

Treatment Option	Benefits	Risks or Consequences
<b>Carpal tunnel decompression</b> This is an operation done in hospital under local anaesthetic. Can be done with an open cut (incision) or with use of an endoscope (keyhole surgery).	80 - 90 in every 100 people are satisfied with the operation at one year post-op.  Performed under local anaesthetic so very little risk of side effects.  Very low recurrence rate.	10 - 20 in every 100 people are not satisfied with the operation at one year post-op, with 8 in 100 feeling they are worse off at two years.  Heavy lifting is not advised for two weeks after surgery. Heavy gripping/pinching is not advised for up to six weeks.  There is a very small risk of injury to the nerve or surrounding structures.  You are left with a small scar (4-5cm) on the inside of your wrist and there is a small chance of this becoming sensitive, painful or thickened.

In making a decision you need to ask yourself - What is important to me? This leaflet and your health professional can tell you the evidence and give their suggestions but you need to make a decision that is right for you. What are your preferences?

You might like to think about:

- Is it possible for me, or am I prepared to wear a splint every night?
- What do I think about having an injection?
- Do I want relief now which might not last, or relief that is more gradual but might last longer?
- Is the problem bad enough that I would want to have an operation?

**Brief Decision Aids** are designed to help you answer three questions: **Do I have options? What are the benefits and risks of these options, (and how likely are they)? How can we make a decision together that is right for me?**

BDA Carpal Tunnel Syndrome V1.7 final pilot version 14.4.12 1st Authors Dr Tom Holland & Dr. Dave Tomson 2nd Author Dr Roland Pratt And Darren Flynn Date written 13.4.12 planned revision date April 2013  
Main sources and supplementary sources © EMIS 2011 Reviewed: 20 May 2011 Doc ID: 4211 Version: 40

The need for decision aids and other support materials to be easy to use and readily available was a common theme raised by participants. However, several participants we interviewed argued that in order for decision aids to be used more widely and consistently, they needed to be embedded in local IT and patient information systems. Research has demonstrated that participants are much more likely to use patient information systems such as decision aids and information prescriptions if they are accessible through simple IT systems.<sup>22</sup>

### **Creating the right consulting environment**

Participants in the evaluation felt that creating the right consulting environment was important for the implementation of SDM. Participants reported that patients seem to engage more with SDM when there are no physical barriers (such as a desk or screen) between the patient and the clinician. Participants felt it was helpful to set up the consulting rooms so that there was no large desk or screen between the clinician and the patient, and the consultant's chair and the patient's chair were at the same height.

We discussed the importance of IT systems to SDM earlier in the report. However, there are still many settings (for example, some secondary care settings) where there are no computers or IT systems available. In these circumstances, participants felt it would be helpful to have pre-printed handouts and other decision support materials so that these are always readily available when the clinician needs them.

### **Changing dynamics between clinicians and patients**

Clinicians described a range of different ways in which they had tried to change the dynamics between themselves and their patients in a way that facilitated SDM. These included using specific words and phrases, using appropriate body language (discussed in more detail below) and tailoring their approach to specific patient needs.

#### *Word and phrases used by clinicians*

MAGIC training and other materials emphasised the importance of consultants using appropriate phrases and questions during SDM encounters to increase the level of patient understanding and involvement (see box below).

#### **Phrases and questions that support SDM**

##### **Example phrases used**

- This is your health we're talking about, I am only here to advise on options.
- What are your fears about your condition?
- What would you like to discuss today?
- Tell me what you thought of the information leaflet.
- Did it make sense?
- What bits don't you understand?
- Going back to what you said at the beginning about your life and experience of the condition, what do you think is best to do now?

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<sup>22</sup> OPM, University of York and GfK NOP (2008) *Evaluation of Information Prescriptions*, London: Department of Health.

Clinicians described drawing on these and other standard phrases and questions to structure their consultations. These words and phrases were described as playing a range of functions, including:

- building trust and empathy
- developing and demonstrating understanding of patients' needs and priorities
- highlighting the roles of patient and clinician in making decisions
- exploring feelings about options and choices
- agreeing a way forward.

#### *Using appropriate body language*

Clinicians who were particularly enthusiastic about SDM also talked about the importance of clinician body language in helping to engage patients with SDM. Clinicians felt that using 'open and welcoming' body language, to build trust and convey that you are listening, was an important way of activating patients in consultations. As part of this, avoiding sitting behind a desk was felt to be helpful, as was allowing patients to be able to see and hold decision tools. For instance, clinicians who have experimented with Option Grids spoke about placing them on the table so that they and the patient could sit over the grid and talk it through. This has helped to promote an atmosphere where the clinician and patient feel they are collaborating and sharing in the decision:

*... the act of handing over the grid and the fact that people end up huddled around it actually quite significantly changes the dynamics in the room – sort of disrupts that relationship between the medical professional and the patient or parents quite significantly. (Nurse practitioner)*

#### *Tailoring SDM to reflect patient needs*

Evaluation participants described varying levels of comfort and willingness to participate in SDM on the part of patients; they cited a spectrum ranging from patients who had tried to share decisions in the past and/or were immediately comfortable with the idea of SDM, to those who were more reticent, and those who were clearly uncomfortable with the idea of SDM.

We know from patients we spoke to who were interested in sharing decisions about their own health, felt confident about their ability to do so, and in some cases had struggled to have their views taken into account in the past, that the introduction of SDM had been very welcome:

*[My interaction with my doctor] is much more two way, rather than "I'm the doctor, you listen." Instead of getting sniffy [if you disagree with them], it's more of a debate. It's almost now as if it's expected that you will ask questions and want information. (Patient in GP surgery)*

In contrast, participants reported that patients who assumed that doctors would take the lead in making decisions were sometimes more reticent about SDM. There were varied responses about how easy or difficult it was to engage these patients with SDM. Clinicians observed that some of these patients responded fairly readily to the invitation to share decisions when encouraged to do so.

However, for other patients, engagement with SDM was reported to be more challenging. Factors including poor health literacy, low self-esteem and confidence, and a deferential

attitude towards doctors and nurses combined to make it difficult for clinical teams engage these patients.

Use of decision making tools in particular could be undermined where patients have low literacy levels:

*Some of the language used is too jargon and complex for the 'average Joe' to understand ... The person's ability to complete those, particularly when you look at the sort of demographics of our population ... that again adds an additional complexity. (PPI panel member)*

Clinicians' approaches to facilitating the engagement of more reluctant or less able patients varied, depending in part on their views about how stringently SDM needed to be applied during the encounter. For some clinicians, if a patient was happy with the information received and their level of involvement with decision making, this was acceptable:

*I think some people take a little while to get used to the fact that you are going to make a decision together rather ... expecting for to the decision to be made for them. That said ... I haven't had anybody that hasn't ... found at least some value from the SDM element of it. They may not make as many decisions as somebody else might but ... as long as they feel happy with the amount of input that they have had in it and the amount of information that they have got back, then, as I say, I'm not too worried about how much they decide themselves as long as the process helps them feel that they've got reasonable value from the consultation and made the right decision. (Consultant)*

In contrast, other clinicians felt that it was important to actively secure a patient's engagement with a decision, even in circumstances where they were reluctant to participate. These clinicians had strong opinions about what constituted 'true' SDM and tended to be particularly enthusiastic about the benefits of SDM, including the opportunity to empower patients to take more control of their health and get better outcomes from any support and treatment received. Where patients were more reluctant, clinicians talked about the need to elicit patients' preferences and values during the consultation by using active listening and, if necessary, probing. They described emphasising to the patient that they are the expert when it comes to weighing up the pros and cons associated with different options and the associated symptoms and side effects. One useful tactic that some clinicians deployed was to tell their patient: 'This is your health and life; you know what is best for you.'

## Extent of achievements

The activities delivered to try to structure clinician and patient interaction in new ways were largely as anticipated in the original programme documentation, focusing on: the introduction and testing of decision aids; creating a suitable environment for the delivery of SDM; and ensuring that clinicians had the necessary skills to put SDM into practice. This section explores the extent to which these activities have influenced clinician/patient interaction across the clinical settings involved.

It is worth reiterating here that the challenges encountered in incorporating patients' perspectives in this evaluation mean we do not have a strong sense of patients' experiences of changes to decision making practice as a result of the programme's activities.

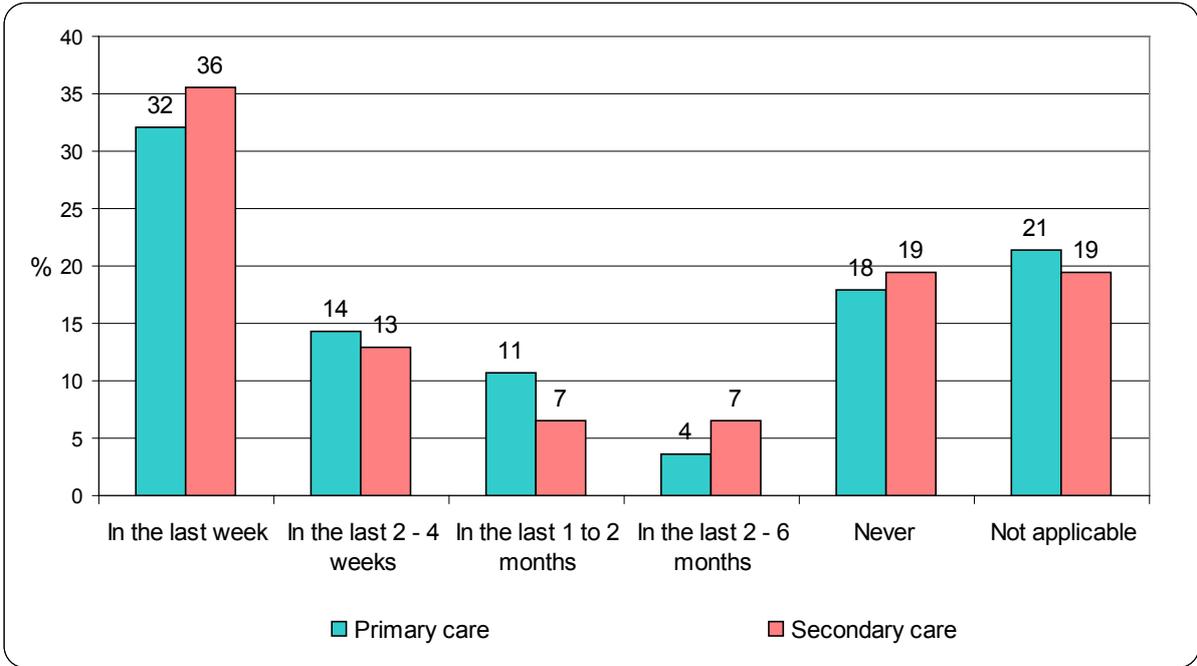
### *Use of Option Grids and BDAs*

Considering the starting position we described earlier – where there were only a limited number of suitable decision aids available and participants had little direct experience of

using SDM tools – the MAGIC programme has been successful both in increasing the overall use of decision aids (especially Option Grids and BDAs) and in introducing new decision support tools that were viewed positively and are being used by many clinicians.

In many secondary care settings, brief in-consultation decision support tools had become central to the delivery of consultations as the basis for discussing treatment options, risks and preferences. This is reflected in a survey carried out with Cardiff clinicians, which showed that 36% of clinicians in these settings had used an Option Grid in the past week, with a further 13% having used them in the past two to four weeks. The use of Option Grids in primary care was dependent on clinicians looking up Option Grids for specific illnesses or conditions. However, despite Option Grids being arguably less firmly integrated in regular consultation practice in Cardiff primary care settings, respondents from these settings were almost as likely to report having used them recently: 32% of clinicians in primary care settings reported having used an Option Grid in the past week, with a further 14% having used one in the past two to four weeks.

**Figure 9: Last time used Option Grid/Brief Decision Aid/booklet in consultations with patients**



Base: Primary care = 28 / Secondary care = 31

Participants from secondary care settings generally reported introducing decision support materials with most, if not all patients. However, clinicians reported that despite their best efforts, not all patients were receptive to using them; instead, they wanted clinicians – and doctors in particular – to provide guidance on what they felt to be the best option for them.

However, evaluation participants observed that even where colleagues were using decision support materials to structure consultations, this did not necessarily mean that SDM was being delivered effectively. For example, they pointed to the potential for these tools being used to describe the choices available to the patient, without this then informing a collaborative discussion between patient and clinician about the former’s priorities, preferences, and attitude to risk. Thus, while just under 50% of clinicians across both primary and secondary care had reported using decision support materials in the previous fortnight, this does not necessarily mean that high-quality, shared decisions were being made.

Decision quality measurement (DQM) tools can measure this, but as explained in the Introduction, data from the DQM were not used as part of our evaluation.

*Availability of suitable environments for delivering SDM*

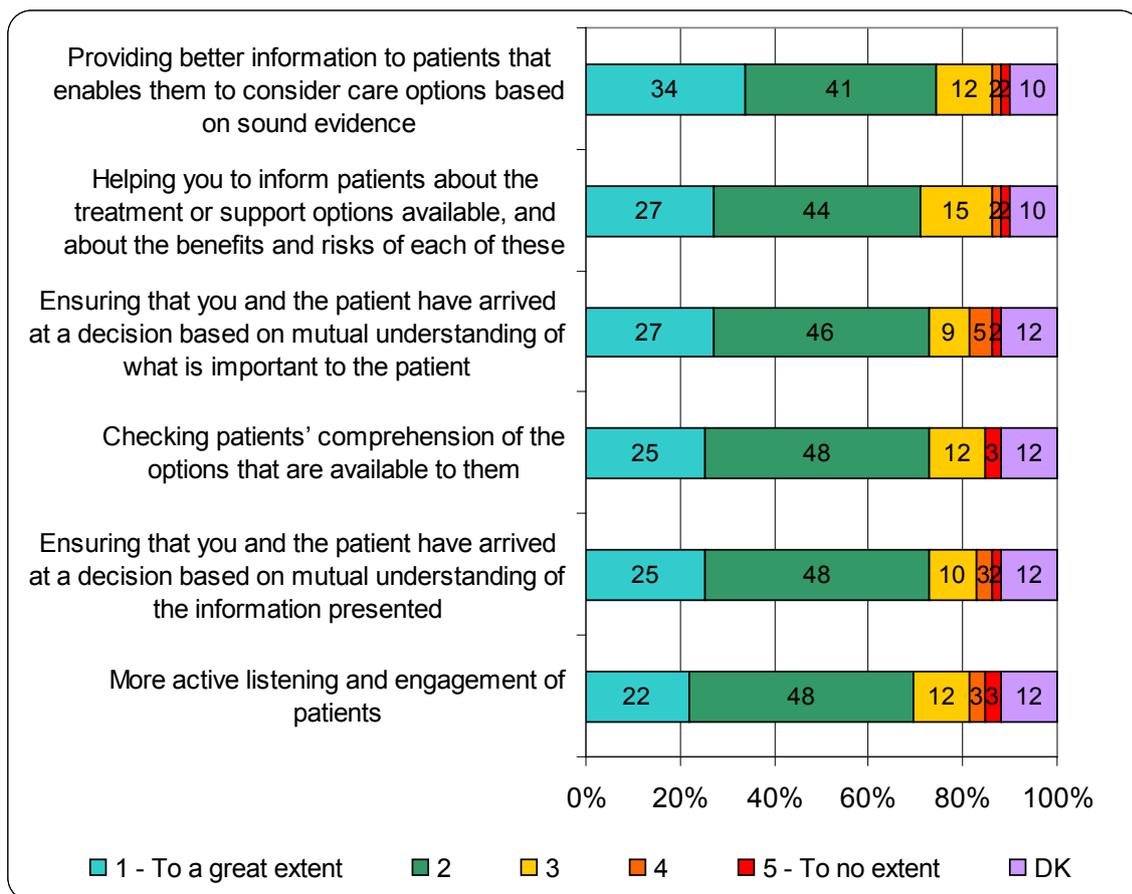
While settings had made some changes to accommodate SDM, securing a suitable environment for the delivery of SDM was an ongoing issue for many teams. Issues relating to clinical settings or premises were sometimes an ongoing barrier to implementing SDM in a way that facilitated changes in patient/clinician relationships.

*Clinician skills*

Survey respondents identified a range of ways in which their interaction with patients had changed as a result of participation in the MAGIC programme.

In terms of what aspects of participants’ practice were influenced by training, the survey results are markedly consistent, with between 70% and 75% of participants indicating that their practice in a range of respects had been influenced to a great extent or to some extent (see Figure 10).

**Figure 10: Effects of participation in the MAGIC programme**



(DK = Don't know)

Base: All (59)

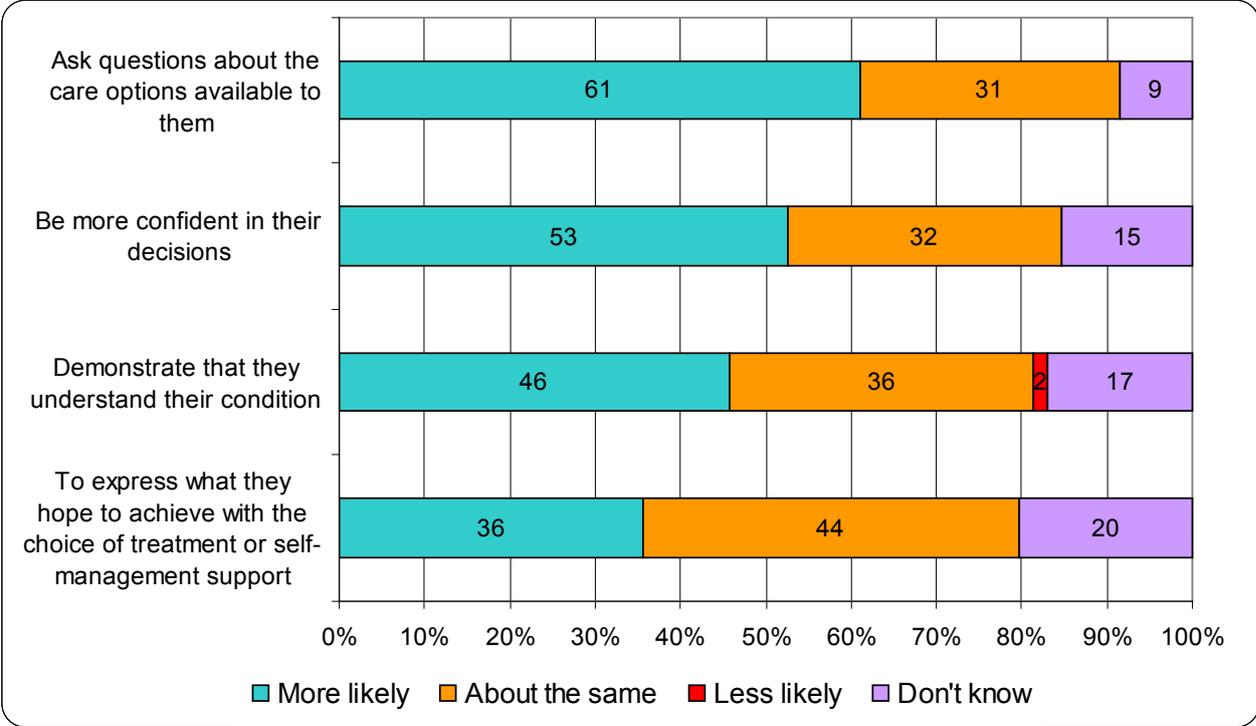
However, while between 70% and 75% of participants reported positive impacts on their day-to-day practice arising from their involvement in the MAGIC programme, 30% did not feel that there had been a positive impact. It is difficult for this evaluation to provide detailed evidence on the reasons for this, as our qualitative research focused on participants who had been more actively involved in the programme and were therefore more likely to have experienced some impact. However, we do know from some of the interviews we conducted that some clinical teams in secondary care had struggled to implement decision tools. This was because they tended to see patients with complex and multiple symptoms, which made decision making very complicated. While there is no evidence from this evaluation to suggest that the MAGIC programme did not work hard to resolve challenges like this in specific teams, the finding may suggest that there are some clinical settings that are less well suited to the use of BDAs or Option Grids.

*I appreciate that MAGIC were hoping to develop some structure to this but I am aware that this was difficult given the multiple sites of tumours and the multiple treatment options. There was no either/or choice and MAGIC could not facilitate this diversity of choice. (Hospital consultant)*

*Impact of changes to clinician/patient interaction on patients*

Participants in the evaluation reported that there had been some changes in patient behaviour as a result of participation in the MAGIC programme. Well over half of participants (61%) reported that in their consultations, patients were more likely to ask questions about the care options available to them (see Figure 11). Almost half (46%) felt that patients were more likely to demonstrate that they understand their condition.

**Figure 11: Impact of team involvement in the MAGIC programme on patients**



## Lessons learned

The evaluation identified a number of lessons about how to structure clinician/patient interactions in new ways as a result of the MAGIC programme:

- While clinicians may have some reservations about the use of decision aids, the use of shorter, locally developed decision support tools was generally felt to work well, and facilitated better quality consultations – and specifically, effective SDM.
- ‘True’ SDM – where clinicians and patients have a shared understanding of patient priorities and options and make a decision on this basis – is unlikely to be delivered using decision aids alone. Changes to the dynamics between clinician and patient are also necessary and will be facilitated by clinicians using a range of skills, including appropriate words and phrases that reflect the key principles of SDM and appropriate body language, as well as being able to deliver SDM in clinical settings which support it.
- Clinicians may have different attitudes and levels of confidence in trying to engage more reticent patients. This means that SDM has the potential to be delivered inconsistently, with some clinicians being more active in trying to engage patients with SDM. It is important to pay attention to this potential variation in how patients respond and for clinicians to work to overcome implementation challenges that may be more significant with some patient groups compared with others.

## 3.6 Embedding SDM in healthcare settings

The sixth and final focus of the MAGIC programme was to embed SDM in the healthcare settings involved. The stated goal of the programme was:

*That senior management teams (managerial and clinical) will have committed themselves to supporting the concept of patient involvement in decision making as a fundamental value which underpins the work of the organisation, and that they have begun the process of aligning incentives and performance measures accordingly.<sup>23</sup>*

This section explores how the MAGIC programme sought to achieve this and the extent of change observed as part of the evaluation.

### Activities delivered as part of MAGIC

#### Building wider support

Reflecting on the MAGIC programme, participants highlighted the essential role played by clinical champions and senior managers in helping to build awareness and ownership of SDM in their wider organisation and local context. These champions were at their most effective when they were able to:

- ‘sell’ SDM at different levels of the organisation
- connect SDM with complementary agendas
- highlight the tangible benefits and SDM success stories to clinicians.

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<sup>23</sup> MAGIC programme initiation document

With regard to the latter point, a common message from clinicians was that SDM will only gain traction among a wider community when there is clear evidence that it will improve patient outcomes.

### *Grand rounds*

In secondary care, grand round meetings were an example of a forum where clinical leads could present their work, providing senior clinicians and lay governors with an opportunity to share their experiences and success stories related to SDM and its implementation. They were also attended by expert patients who were able to demonstrate to clinicians the potential benefits of SDM for patients. This helped clinicians to connect with the idea of SDM, and to see that it had the potential to transform the patient experience. As a result, there was an increase in understanding of the concept, particularly now that the teams are able to talk about their experiences of SDM in practice.

In Cardiff, for example, as a result of SDM promotion during grand rounds, the trust's renal team approached the MAGIC team with an interest in trialling SDM in their own setting.<sup>24</sup> Responding to this request, members of the MAGIC core design team began meeting the team on a monthly basis to support them in developing their practice. The interest of the renal team was triggered by viewing some of the DQM data from the breast care team.

As well as having benefits for the wider organisation, the online survey points to the positive value of taking part in grand rounds for the teams that presented their work: 33 out of 47 participants (70%) indicated the showcase events as 'extremely helpful' or 'somewhat helpful' in implementing SDM in their setting.

### *Executive walkabouts*

Executive walkabouts carried out in both primary and secondary care settings at several points along the programme represented another approach to organisational engagement that was widely felt to have been successful. Each walkabout involved board members and senior managers visiting a number of participating teams to gain an update on the work they had been doing as part of the MAGIC programme, followed by a discussion.

The MAGIC core design team observed the following positive benefits of this approach for the participating teams:

- It demonstrated that there was senior-level commitment to MAGIC.
- It resulted in greater sign-up (especially consultants) to the skills workshops.
- Teams valued being able to showcase their work.
- Team members began to take the programme more seriously and there was increased interest from those who had not been very involved up till that point.
- Board members learnt about the use of DQMs and were able to assess their wider potential.
- Visiting several teams on the same day enabled comparative discussions of the work and showed the different ways in which SDM could be applied.

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<sup>24</sup> However, this is not an isolated example. In Newcastle, other clinical areas have expressed an interest in benefiting from SDM, including the areas of pharmacy, intensive care, birthing centre and pre-assessment clinics.

## *Showcase events*

In the later stages of the programme, the MAGIC core design team worked with the participating trusts to organise showcase events which generated interest and awareness of the benefits of the programme within the organisation and the wider health economy. These events were largely interactive, with the clinical leads presenting their challenges and solutions as well as members of the PPI panel providing their perspectives. The sessions began with initial presentations, after which the venue was converted into an exhibition with different stands representing key outputs from the programme. Delegates also had the opportunity to speak to members of the team and ask questions.

Reflecting on their impact, the MAGIC team felt they had a valuable impact both on clinical teams and more broadly within the participating organisations in further raising the profile of SDM and promoting its importance from a national perspective. Again the online survey of participants confirms this broadly positive view, with 22 out of 33 (67%) characterising the showcase events as 'extremely helpful' or 'somewhat helpful' in implementing SDM in their setting.

## **Making changes to organisations/systems to accommodate SDM**

### **Supporting and monitoring improvement**

The central aspiration of the MAGIC programme was to improve the quality of decision making. Decision quality refers to the extent to which patients are knowledgeable about the key options open to them and involved in decisions about their care, and the extent to which the treatment they select matches their preferences. The measurement of the quality of SDM was regarded by the MAGIC core design team as critical to establishing whether SDM has improved clinical practice and to assess whether SDM was being implemented in a way consistent with the MAGIC training and approach. Data collection also played a crucial role in creating a culture of learning and improvement within teams.

This involved:

- developing and testing data collection tools to measure progress and impact
- using SDM data to influence clinicians' attitudes and drive organisational change.

It is important to note that the MAGIC programme did not use data collection to measure clinical outcomes and did not attempt to establish a robust process for tracking impact on patients over time through baseline and follow-up data collection.

### **Developing tools and systems to measure progress and improvement**

The participating clinical teams piloted several instruments and processes for measuring progress and impact as part of the MAGIC programme. Participants reported that the development of the instruments was time-consuming, with tools and processes generally going through several iterations. Clinical teams also reported having initial concerns about how willing patients would be to complete SDM questionnaires and other measurement tools, particularly following consultations where they had received bad news, or where they were eager to leave clinical settings to go home. Measuring progress and impact was widely recognised as being one of the most challenging elements of the programme but also an area where there has been considerable learning.

Reflecting on the experience of developing tools, the MAGIC core design team emphasised that clinicians are more motivated to use tools where they:

- have been actively involved in developing the measures
- provide data that informs their clinical practice
- are supported by simple and ‘hassle-free’ administration and analysis processes
- provide opportunities to hear the patient voice
- are administered at an appropriate time to patients (that is, not immediately following a potentially distressing diagnosis, for example).

### *SDM patient experience questionnaire (SDMQ)*

The SDMQ was a generic questionnaire developed by the MAGIC core design team in collaboration with the participating clinical teams. It used a series of closed questions which asked patients to assess the extent to which they have been involved in making choices and decisions about their care and treatment during their appointment using a five-point scale. SDMQs were typically completed by patients at the end of the diagnostic stage or at one point in the care pathway and were either handed in to a receptionist or returned by post.

As part of the MAGIC programme, each participating team was tasked with administering the SDMQs to their patients. The MAGIC team conducted several rounds of analysis and the results were then presented at the team level or as clinician-level feedback. As each round of data was analysed, the results could be compared month on month.

The SDMQs piloted in MAGIC took time to develop and there were several iterations as the teams across Cardiff and Newcastle made suggestions about how the wording should be modified in their efforts to capture more accurate data.

There is some evidence from our evaluation that some participants found the feedback provided by the analysis of the questionnaire data helpful – particularly where it was individualised at clinician level. However, as an improvement tool, SDMQs were widely felt to have significant limitations.

Administering SDMQs was reported to be a burdensome process, particularly for practice managers and team administrators who were tasked with distributing and collecting them. This meant that many teams struggled to achieve the completion targets that were set early on by the MAGIC core design team. The low number of returns meant that the data presented back to the teams were felt to have limited value by the participating teams. This process of asking teams to administer surveys was reported by some participants as giving the impression that the programme was more of an academic research study than a change or quality improvement programme, which led some to disengage from it.

Another key issue was that SDMQs failed to elicit the sort of critical data that clinicians would require to reflect on and improve their practice. This is because patients chose to complete the questionnaire as if it were a satisfaction survey, and out of deference or perhaps a lack of confidence, gave uniformly high scores.

*Most patients never want to do any criticism at all, sometimes they'll actually fill questionnaires in before you've even seen them ... They'll just go "You're always wonderful and you always do your job properly". So we've had to stop giving them the questionnaires before they come in. (GP)*

Clinicians also talked about the fact that the SDMQ was not able to provide any ‘real-time’ data that they could use to assess patients’ information needs or preferences and actively respond to them (unlike DQMs, discussed below). Instead, there was a view that the data reflect patients’ general satisfaction with the service, rather than their involvement in decision

making. There was a firm view from participants and the MAGIC core design team that further work on the questionnaire would be required in order to address these issues, including reporting the change in level of negative responses rather than the high rates of positive response.

### ***Decision quality measures (DQMs)***

DQMs are condition-specific diagnostic tools that use a series of questionnaire measures to ascertain: a patient's understanding of the key features of a set of treatment options; their preferences (what is important to them); their readiness to decide; and their preferred choice of treatment.

They are often administered at two points in the care pathway. For example, in the breast care team, patients were asked to complete two DQMs: the first at the end of the diagnostic consultation and the second at the end of the home visit, and to return it by post.

In the MAGIC programme, each DQM was developed in close collaboration with the relevant participating team. In most cases, the MAGIC teams worked with the clinical teams to edit and simplify the DQM down to the core elements so that they were streamlined and simple to use during consultations with patients. In contrast to the feedback elicited on the SDMQ, participants were largely positive about this instrument, believing it to be a helpful tool for improving their practice, as highlighted in the box below.

#### **Benefits of using DQMs identified by clinicians**

- DQMs can provide clinicians with valuable real-time data which allow them to 'diagnose' patients' knowledge and preferences, and ensure alignment between preferences and treatment in the clinic.
- They provide clinicians with data on decision quality so that they can make improvements in their behaviour/practice to ensure that better quality decisions are reached.
- DQMs have the potential to be used as medico-legal documents; a record of decision process and understanding.
- DQMs can be used to test different types of language used in option grids.
- DQMs provide data which can help clinicians test their delivery of SDM.

While the clinical teams highlighted a range of benefits of using DQMs, not all teams have had entirely positive experiences. For example, one GP practice decided to discontinue the piloting of DQM following concerns about whether patients understood the questions, and a view from staff that they were too onerous to administer. This experience highlights the importance of the development work that is required upfront on the wording and accessibility of the instrument, as well as the value of creating a shared narrative and rationale for using the tool.

#### ***Use of EMIS codes to capture SDM activity***

Alongside questionnaires that are completed by patients, several of the primary care teams have piloted simple ways for clinicians to 'log' their SDM activity during consultations with patients. This has been achieved by establishing one or several SDM activity codes (for example '*Patient offered choice of treatment*') which can be logged on their EMIS patient record system. As clinicians get into the habit of routinely coding SDM activity, practices are

able to monitor the total number of SDM consultations and the number of clinicians using them.

As well as providing monthly feedback to clinicians, one practice conducted an audit of three months' worth of coding data and fed back the individualised results to the whole clinical team.

The routine data collection supported by EMIS has allowed several practices participating in the MAGIC programme to keep a running score of how much SDM activity individual clinicians have conducted. This has been used as a way of encouraging light-hearted competition between clinicians as well as serving as an ongoing reminder to them to practise SDM and code their activity.

Clear differences between primary and secondary care were identified in how easy the software is to use for recording SDM. While primary care benefits from having a single integrated software system, the more fragmented IT systems used in secondary care were identified as raising a number of challenges for monitoring SDM activity. Due to the programme having little focus on the role of IT systems in supporting SDM, few suggestions were identified through this evaluation as to how these challenges could be addressed.

### **Incentives and competitions**

Participants felt that there was a lack of incentives to engender a long-term commitment to SDM by staff, such as payments for the successful delivery of SDM or a clear recognition in appraisals of staff having embraced SDM and delivering it effectively. While the MAGIC programme trialled the use of low-level incentives – for example, the weekly 'MAGIC Cup' that was built around EMIS coding in primary care teams – participants, particularly middle and senior managers, felt that there was a need to focus on how performance management systems and the use of targets have the potential to act as system levers that would help to embed and sustain SDM in the health system.

In primary care, practice managers in particular felt that SDM needed to be incorporated into the Quality and Outcomes Framework (QOF) given the extent to which it influences patient consultations and '*the whole running of primary care*':

*With something as big and important as SDM, it would be good to get it on the QOF that GPs work to. QOF has taken on many quality and productivity elements but not SDM – we should lobby for this. (Practice manager)*

However, participants added that simply including SDM within QOF would be unlikely to deliver the sort of genuine change in culture and practice that is required to deliver 'true' SDM.

*QOF is one of those things that creates another hoop. We jump through the hurdles and deliver whatever QOF wants, but it doesn't follow that that will deliver genuine change. (GP)*

### **Commissioning arrangements**

While there was limited evidence that SDM had begun to be actively factored in to commissioning processes, several senior managers who participated in the evaluation explored how SDM could be aligned with particular commissioning indicators. In Cardiff, a board-level participant in the trust talked about the potential to include SDM in the Welsh Annual Quality Framework (AQF) that sets out a programme of change and improvement in a five-year plan. In Newcastle, a senior manager noted that there were at least two indicators

in the English Commissioning for Quality and Innovation (CQUIN) framework that could potentially be used to drive the implementation of SDM – something which the trust intends to explore further. These were felt to be particularly appropriate mechanisms for gaining buy-in from middle managers who may feel overwhelmed by competing priorities and targets that they may regard as ‘having equal prominence or importance’. As in primary care, there was again a view from participants that indicators are only part of the answer if the goal is to effect a longer-term culture change towards effective SDM.

Looking forward, participants reported that there is a need to understand the role played by commissioners and providers in shaping a health system that supports SDM. As clinicians take on an increased role in overseeing commissioning budgets, SDM will have to be reconciled with cost constraints and the local availability of clinical options.

### **Education, training and personal development**

Reflecting on how SDM might be embedded in their organisations, participants from both primary and secondary care pointed to the need to include SDM training in the undergraduate curriculum for doctors and nurses. While explicit training in SDM would be a vital mechanism for embedding, as noted previously in this report, this would be building on a medical curriculum that is currently more in line with an SDM approach than it has been in previous decades:

*Thankfully, new doctors now have far better training in communicating with different patients. It's about having strong, active listening skills and being able to explain complex information clearly. (GP)*

Alongside undergraduate training, there was a strong and consistent message that in order for SDM to be embedded, it will need to be well integrated into health professionals' ongoing training and personal development – something which was being actively considered by managers in participating trusts and GP practices at the time of the evaluation fieldwork. For example, in Newcastle, the trust is considering how their education and training department could begin to build SDM into its existing organisational development training as well as its frontline skills training and training evaluation procedures. In a primary care setting in Cardiff, the GP lead talked about how SDM is viewed as part of clinicians' ongoing focus on communications skills. It was also emphasised that SDM fits in well with ongoing staff professional development and appraisal processes, offering a good model and training for clinicians who are focused on analysing and improving their consultation skills.

There was also a suggestion that SDM needs to be included in the medical revalidation process, and it is hoped that as clinicians start to see routinely captured SDM patient feedback data, they will become better able to critically reflect on and modify their practice on an ongoing basis.

#### *Embedding training and development activities*

Thinking about sustainability and wider roll-out, several participants argued that the value of the training in the early stages of the programme was such that attendance should be mandatory, with mop-up sessions arranged so that all team members can access the training. It was recognised, however, that this would require top-down pressure from managers and clinicians being able to guarantee protected time for it.

## Alignment with complementary agendas

Embedding SDM required senior champions who were able to link SDM with complementary agendas and workstreams, such as quality and safety and innovation and improvement. In the view of one senior manager in Cardiff, making these sorts of linkages helped to ensure that SDM was viewed as a mainstream activity that was helping the trust to address its 'core business':

*At some point this all has to become mainstreamed. At what point do you start to say "This isn't special or different – it's how you should be working all the time"?* (Senior manager)

As well as promoting SDM from the top down, in Newcastle, the MAGIC core design team noted that several new teams that wanted to participate in SDM saw it as an opportunity not only to improve their service but to fulfil some of the requirements to meet new standards and targets such as improved patient consent processes, changes to the NHS Litigation Authority, and changes to standards in patient information.

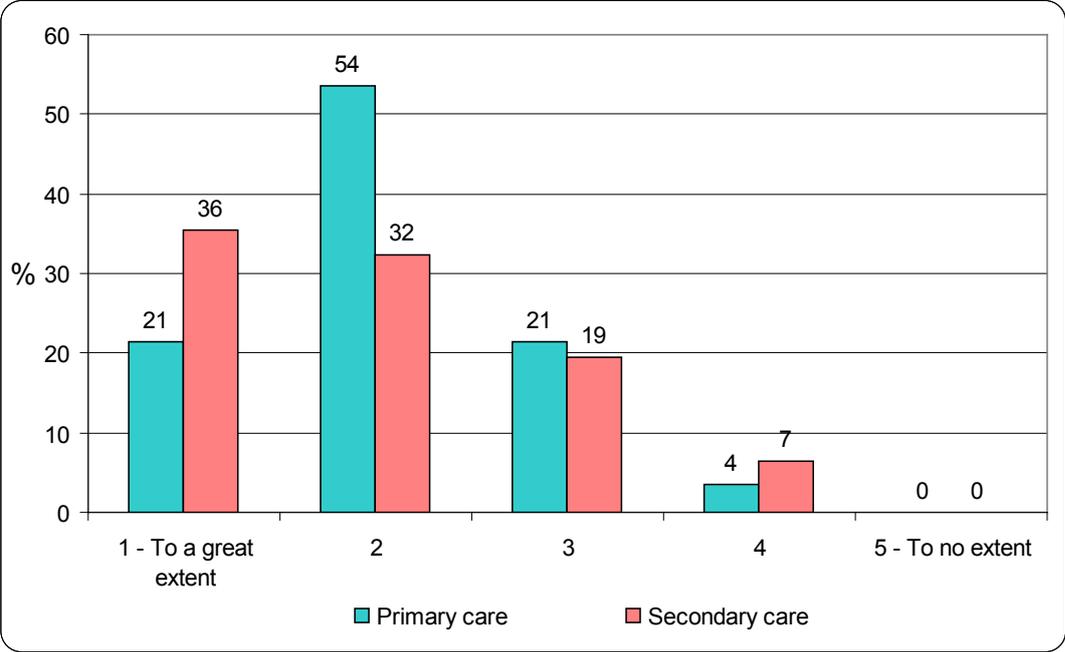
## Extent of achievements

As with the previous objectives, the activities that were carried out during the programme to embed SDM in healthcare settings were largely consistent with the planned activities identified in early programme documents.

The findings from this evaluation suggest that while there appeared to be a critical mass of clinicians who wanted to see SDM embedded in their clinical practice and had identified strategies for doing this, the process was still in its early stages. At the time of the survey, 29% of respondents believed that SDM had become a core characteristic of routine clinical care in their settings/practice to a great extent (with 40% indicating that this was the case 'to some extent') (see Figure 12). The proportion of participants who said that SDM was a 'core characteristic of their routine practice' was broadly similar across primary and secondary care. However, SDM appears to have been slightly more firmly embedded in secondary care (with 36% strongly agreeing in these settings compared with 21% in primary care). It is difficult, from the evidence collected in this evaluation, to explain this difference, but the fact that decision support materials were more widely adopted in secondary care settings than in primary care could provide part of the explanation.

Considering the starting position, where few teams had previous experience of implementing formal and structured elements of SDM such as using decision aids in routine practice, the programme has made significant progress in embedding certain aspects of SDM. There has also been progress in some of the clinical teams in terms of redesigning care pathways to facilitate SDM, although many teams have made informal 'tweaks' to pathways rather than redesigning whole pathways.

**Figure 12: Extent to which SDM is believed to have become a core characteristic of routine clinical care in local settings/practices**



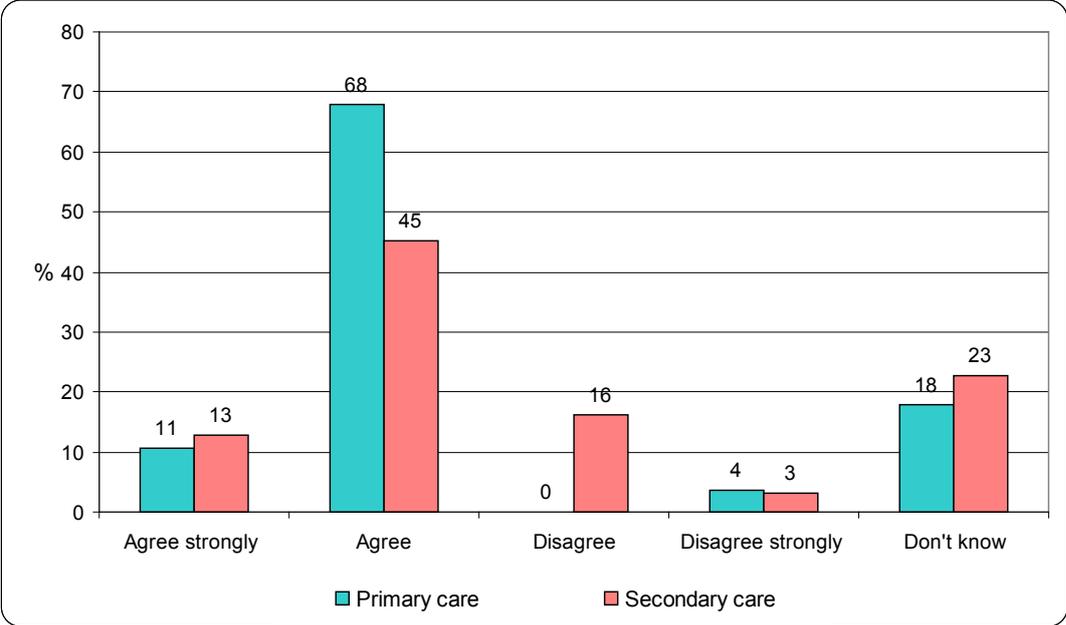
Base: Primary care = 28 / Secondary care = 31

The survey suggests that the MAGIC programme has made some progress in promoting the mainstreaming of SDM in the clinical settings in which it is delivered. For example, 43% of participants in both primary and secondary care agree or strongly agree that senior managers and commissioners actively and visibly promote SDM as an integral part of patient care. Participants working in primary care were much more likely to report that there were explicit agreements that SDM principles are supported by their organisation (with 78% agreeing or strongly agreeing with this statement, compared with 46% in secondary care).

In terms of sustainability, there was a dramatic difference between primary and secondary care, with 79% of participants working in primary care reporting that the SDM practices and processes developed in their clinical setting as a result of involvement in the MAGIC programme are sustainable, compared with 58% in secondary care (see Figure 13).

While we do not have a firm sense of the reasons for this reported difference, a small number of participants posited that it might be due to primary care staff having more regular and often longer-term relationships with patients. This may enable them to build a deeper knowledge and understanding of the needs and values of individual patients compared with their colleagues in secondary care. Other explanations may lie in the more concentrated team working being undertaken in some GP practices and arguably higher degree of control they have over their settings. But again, these hypotheses should be treated with a degree of caution, and could be explored in further evaluation of the MAGIC programme.

**Figure 13: Sustainability of practices and processes developed in clinical settings as a result of involvement in the MAGIC programme**



Base: Primary care = 28 / Secondary care = 31

**Lessons learned**

The evaluation identified a number of lessons about what needs to change to ensure that organisations and systems accommodate SDM.

- Human resources (HR), organisational development managers and managers involved in learning should commission training on SDM for staff at all levels of the health system.
- Managers should explore how current patient outcomes and satisfaction measures can be improved to incorporate measures that assess the extent to which shared decision making is being practised.
- Managers and senior clinicians should explore ways to embed SDM into a range of organisational arrangements and plans such as strategy documents, service plans, QIPP (Quality, Innovation, Productivity and Prevention) plans, and workforce development strategies.
- Those responsible for commissioning should review how current commissioning processes contribute towards SDM with the aim of embedding commitment and building measures that incentivise SDM into the contracting regime. This might involve introducing performance measures that incentivise providers who deliver SDM and ensuring that providers with a track record of promoting SDM are actively engaged in commissioning arrangements.
- Senior designated staff, who will take a lead in coordinating the implementation of SDM, must be identified within organisations or services.

## 4. Conclusions

This section of the report is separated into two parts: the first provides a set of overarching conclusions, while the second provides a more detailed analysis of specific conclusions in three broad areas:

- creating the right leadership, culture and behaviours to implement SDM
- delivering and embedding SDM in clinical settings
- creating a system that is ready for SDM.

### 4.1 Overarching conclusions

#### Overall impact

It was beyond the scope of the evaluation to undertake an impact assessment of the MAGIC programme. However, this evaluation has identified compelling evidence that the programme has contributed to a range of improvements, both for individuals engaged in the programme and wider teams and services.

Taken as a whole, the programme has enabled a number of teams to make significant progress towards implementing many of the main features associated with shared decision making (SDM).

Across the programme, there is an increased awareness and knowledge of both the principles and practice of SDM, increased use of decision support tools, an increased number of managers and clinicians who are committed to SDM, and greater adoption of practical consulting or care-giving approaches that empower patients to make shared decisions with their clinician. Several teams have been able to embed the use of decision aids in clinical encounters, including using Option Grids and BDAs as a guide to clinician-patient encounters.

There was less evidence that the programme made sufficient progress in finding effective and sustainable ways to engage patients and some groups of clinicians. The efforts to develop patient surveys, while useful in creating learning about what tools might work beyond the scope of this programme, were seen to have diverted attention and resources away from more practical efforts to implement SDM. The Ask 3 Questions campaign materials developed by the programme are viewed favourably. However, there was limited progress in rolling these out on a large scale and assessing their impact on patient awareness and activation for SDM. While some clinical teams managed to instigate changes in care pathways to incorporate SDM, most teams did not make significant progress in redesigning pathways.

However, even where there was less progress in relation to the delivery of some of these interventions or their impact on patients, the programme has been able to leave a legacy of tools, materials and data collection measures that could be picked up and used by others. For instance, the Ask 3 Questions materials could be used by organisations as part of new campaigns to raise patients' awareness of SDM.

## What worked well or less well?

This evaluation has identified the following areas as being most successful in supporting the programme to achieve its objectives.

- The delivery of advanced skills development sessions, which emphasised the practical application of SDM techniques and approaches within clinical encounters.
- The involvement of senior leaders in building commitment and understanding of the benefits of SDM.
- The use of decision quality measures (DQMs) to aid data collection from patients and provide real-time feedback to clinicians.
- Working with teams to develop brief in-consultation decision support materials to support SDM within clinical encounters.
- The use of action learning techniques to support collaboration and shared learning between different clinical teams.
- The use of quality improvement (QI) methods within teams to enable them to test and implement small-scale changes while providing a clear, structured plan for stakeholders to follow.

There were also a number of the programme's design features that appeared to work well:

- The holistic focus of the programme sought to engage participants through a range of activities and address a number of different issues, ranging from leadership styles and behaviour and culture, through to systems, processes and metrics:

*In contrast to some programmes I have been involved in, MAGIC understood that we don't just need a new IT system or a new change tool, but we need to be challenged in terms of our values and practices. (Doctor)*

- The delegated and devolved nature of the programme's engagement with clinical teams emphasised the importance of local teams being largely responsible for identifying and delivering improvement rather than having solutions imposed from above.
- The recruitment and development of local champions who coordinated and led projects within clinical teams.
- A positive and appreciative approach to engaging teams placed the emphasis on what was already working well and how good practice could be built on.
- The use of skilled local facilitators who had a combination of practical experience of implementing SDM and a clinical background strengthened credibility and was helpful in supporting local improvement efforts.
- The use of QI methods provided a framework to help clinicians test changes and understand whether they were making effective improvements on a regular basis.
- Local design team meetings were used as a way of engaging local champions and clinicians in sharing learning, contributing to the delivery of the programme and identifying solutions.

The mix of skills and experience offered by the MAGIC core design team was also seen as important. The team was felt to offer the right mix of organisational development and leadership skills, deep knowledge of the evidence and practice of SDM, understanding of the clinical context and the challenges facing clinical teams, and experience of change approaches such as quality improvement methods.

In the box below, we try to capture some of the key features of the MAGIC programme which underpinned its success, categorised in terms of: delivery team skills and capabilities; management of programme delivery; approach to engagement with clinical teams; activities; and tools and approaches.

<b>Skills and capabilities</b>
<ul style="list-style-type: none"> <li>• Mix of clinical, organisational development, research and knowledge of practice of SDM</li> <li>• Involvement of local facilitators recruited from local clinical settings to lead change and provide peer support</li> </ul>
<b>Management of programme delivery</b>
<ul style="list-style-type: none"> <li>• Local design team meetings involving local champions and core design team members to share learning and identify solutions</li> <li>• Provision of support to develop tools and data collection</li> </ul>
<b>Approach to engagement with clinical teams</b>
<ul style="list-style-type: none"> <li>• Decision making and delivery delegated to local teams</li> <li>• Identification of, and support to, local champions</li> <li>• Appreciative approach to engaging teams</li> <li>• Tailor training to reflect different roles of clinicians and specific clinical expertise</li> </ul>
<b>Activities</b>
<ul style="list-style-type: none"> <li>• Quality improvement methodologies</li> <li>• Advanced skills development</li> <li>• Action learning approach</li> <li>• Peer support from local facilitators</li> </ul>
<b>Tools and approaches</b>
<ul style="list-style-type: none"> <li>• Decision quality measures (DQMs)</li> <li>• Shared decision making questionnaires (SDMQs)</li> <li>• Brief Decision Aids (BDAs)</li> <li>• Option Grids</li> </ul>

This evaluation has also identified the following areas that were less successful in enabling the programme to achieve its objectives:

- While the idea and materials for the Ask 3 Questions marketing campaign were viewed positively, there is less evidence that they had the desired impact on patient awareness or levels of patient activation. It will be important to test this approach on a larger scale, with follow-up research on impact to assess its potential benefits in raising patient awareness.
- Questionnaires or measures which capture the extent to which SDM is occurring will be an important component of any system-wide regime to support the embedding of SDM.

However, the SDM patient experience questionnaires (SDMQs) were not used consistently and effectively within this programme, leading to a misuse of resources and distracting participants from other tasks.

- Patient engagement forums (patient and public involvement (PPI) panels) were not as effective as envisaged in supporting the programme. This was partly due to poor attendance but also because the panels could not always enable patients to engage meaningfully with the practice of SDM.
- National coordination between the two sites, facilitated mainly through core design team meetings, was seen as less helpful compared with more locally focused support activities. This was due to the difficulties in getting the teams together.

### **How could this programme be sustained?**

Phase 2 of the MAGIC programme had started prior to the publication of this evaluation report. The programme will continue to focus on providing support to specific clinical teams to help them embed SDM.

It was beyond the remit of this evaluation to follow-up clinical teams involved in phase 1 of the programme. We cannot, therefore, comment on whether progress made with implementing SDM in these settings has been sustained, and what constitutes successful strategies for achieving sustainability. However, the evaluation suggests that making the following components available to clinical teams may be important in order to sustain the delivery of SDM.

- **A network of local peer facilitators** – organisations with an interest in implementing SDM locally should develop networks of peers with knowledge of SDM to support local teams to take forward specific projects. They could be recruited by local clinical commissioning groups (CCGs) or health boards and be designated to support the take-up of new tools, processes and systems in specific settings.
- **Training for local SDM champions** – local champions need to be recruited and trained by CCGs or equivalent bodies to implement SDM. This evaluation has found that the local champions in the two sites played a crucial role in providing support to local teams. However, they need to be given the freedom to work on implementation projects largely independently of national or regional bodies.
- **Skills development programmes** – modelled on the MAGIC training programme, local provision of skills development should be made more widely available. A range of organisations, including CCGs (and health boards in Wales), national leadership development organisations, and providers of training, such as Skills for Care, all have a role in making skills development opportunities accessible.
- **Specialist advice on developing and using Option Grids and BDAs** – Option Grids and BDAs have the potential to provide a faster and cost-effective way of developing structured tools to support SDM. Resources should be made available at the local level – perhaps working with clinical networks – to develop decision support materials for a range of conditions.

## **4.2 Creating the right leadership, culture and behaviours**

The MAGIC programme was largely successful in engaging a broad range of stakeholders within a set of committed teams, involving more than 270 participants in the training programmes alone. The evaluation found evidence that the programme had succeeded in building participants' understanding and awareness of SDM, and equipping them with the

skills and confidence needed to apply it in their everyday practice. However, the programme did struggle to secure the participation of some other stakeholders, particularly senior hospital consultants, GPs and clinicians. The overarching lesson from the difficulty of engaging these groups was that greater evidence is needed to convince them to adopt SDM – particularly evidence of its impact on clinical and patient outcomes.

The programme succeeded in securing high-level buy-in from a number of senior managers, which was critical to its overall success. Programme participants found it helpful to have clear leadership and support from above and active engagement from leaders in the detail of the programme.

The evaluation has identified the language and communication strategies used by the MAGIC programme as being particularly important in engaging stakeholders. Clinicians told us they found that the language used by the programme – which emphasised that SDM was about building on skills they already had rather than overhauling them – helped them to understand that this was not necessarily a radical departure from existing practice. They also found the focus on the impact of SDM on patients helpful in encouraging them to take part.

The approach to skills development deployed by MAGIC was also successful both in engaging clinicians and helping to change their behaviours and practice. Clinicians reported finding the practical focus of the training – which allowed them to translate the theory underpinning SDM into routine practice – important in helping them to visualise and understand what SDM would mean in practice. Stakeholders widely reported that they would appreciate an expansion of the training over the coming years to include a wider range of colleagues and regular refresher courses.

There is also evidence that the MAGIC programme successfully changed clinical practices, with many participants reporting that they will continue to use SDM approaches in future. For instance, participants in the clinical teams who originally reported having little knowledge of SDM told us that they are now using decision support materials regularly as part of routine care. In addition, they reported finding DQMs to be a helpful mechanism for regularly eliciting feedback from patients on their practice, and want to see the tools used more widely.

In summary, we can conclude that the following MAGIC programme activities were successful in building ownership and supportive behaviours in relation to SDM.

- Making the case for SDM with senior leaders, including members of trust boards, strategic managers and commissioners.
- Recognising and tapping into different staff motivations; this facilitates the implementation of SDM tools such as DQMs, patient experience surveys (SDMQs), BDAs and Option Grids.
- Making evidence available – even if it is not yet scientifically validated – to convince clinicians that SDM can make a difference to patient outcomes. Producing better evidence on how SDM can reduce costs and unnecessary referrals will also be important to convincing clinicians in the future.
- Ensuring that all clinical staff take part in at least one round of training on SDM. For those who become more deeply involved in implementation, extended skills training is necessary to build knowledge and specific skills.
- Using role play exercises and practical skills training to embed specific skills.
- Using feedback from patients about SDM to communicate its benefits to individual clinicians and members of staff.

- Training project teams in quality improvement methodologies and using these methods to guide small-scale implementation projects – for example, to test a new decision aid.
- Raising awareness and commitment levels among clinicians through facilitating visits or presentations by senior clinical experts who have successfully delivered SDM interventions elsewhere.
- Using networks of clinical peers with knowledge of clinical specialisms to support other clinicians with implementation. These ‘local facilitators’ can help to inspire colleagues and keep them focused on implementation.

### 4.3 Delivering and embedding SDM within clinical settings

The MAGIC programme successfully supported clinical teams in testing and developing a range of SDM tools, approaches, and changes to clinical practice. This included DQMs, SDMqs, BDAs, Option Grids and marketing campaigns. While it has not been possible within the scope of this evaluation to conclude which of these tools had the most or least impact, we can conclude that there was widespread use and positive feedback on many of the tools that were piloted. This is especially true of the Option Grids and BDAs, which were widely reported as being simple to use, effective at promoting consistent practice across clinical teams, and easy for patients to engage with.

Local clinical champions were critical to the success of the programme. Without committed clinical champions, based within clinical teams, it is unlikely that the programme would have been as successful. For instance, one of the clinical teams reported that it was forced to leave the programme when its clinical champion had to leave the organisation half way through the programme and was not successfully replaced. Stakeholders also reported that they found the local facilitators to be very helpful in providing regular encouragement and support.

The involvement of patients in the MAGIC programme was seen as a critical success factor. Patients, once successfully involved, played an important role in developing patient-centred tools and materials and in offering advice on implementation.

The MAGIC programme had some success with piloting a range of marketing campaigns to encourage patients to take part. However, stakeholders felt that additional efforts would be required to ensure that patients properly understood SDM and their role in promoting its implementation. This would require extensive outreach and development work with patient representatives and expert patients in future.

Quality improvement (QI) methodologies were regarded as an effective approach to implementing changes and new tools, with stakeholders reporting that QI methods provided a helpful way of structuring their projects as well as promoting a culture of continuous learning. However, not everyone who took part had pre-existing knowledge of quality improvement, so it is important that training in QI is made available at an early stage in similar programmes to all clinicians engaged in implementation.

There is evidence that the programme attempted to do too much too soon in some clinical teams. The programme would have benefited from delivering activities gradually, perhaps in phases, limiting the number of specific activities each team was involved in at any one time.

The MAGIC programme achieved some progress in encouraging participants to redesign care pathways in order to reflect SDM. For instance, one clinical team succeeded in redesigning their pathway to introduce increased opportunities for patients to discuss and consider care options. However, other teams faced considerable challenges in changing

existing pathways due to a mixture of resistance from senior clinicians and the complexity of the care settings they worked in. More work will be required to explore how care pathways need to be designed in the future, especially in primary care.

Other specific conclusions from the evaluation are as follows.

- It is beneficial to involve staff with previous experience of SDM in driving the work of local implementation teams.
- The programme would have benefited from having a simple diagnostic tool to test the readiness of clinical teams to engage in the programme and determine what support they needed.
- It is important to start with a narrow patient group or clinical specialism and then expand into other clinical areas or activities when the team is more confident in what it is doing.
- Demonstrating high-level support for SDM is an important way in which the team has engaged clinicians. Visible board-level support, with visits from the hospital's medical director and members of the board, have been very effective, as has influencing work undertaken by a respected patient representative.
- When managing implementation of projects, it is important to adopt a facilitative, non-directive approach whereby teams have the freedom, choice and flexibility to pursue the issues they choose, using the approach that they believe will work best in their setting.
- It is important that there is a good mix of staff within local project teams, including clinicians at all levels of seniority (including nurses), support staff and those with IT skills.
- It is important to find opportunities to demonstrate the benefits of SDM in order to build support and commitment for the changes necessary to implement and embed it. DQMs, which provide rapid patient feedback on SDM, and simple patient surveys, can be useful tools for demonstrating to sceptical clinicians that patients have benefited from SDM.
- A wide range of opportunities need to be utilised to increase patients' awareness and understanding of SDM, including information giving, encouraging staff to raise questions with patients about their care options before they see their clinician, and through advocacy, patient forums and self-help groups.
- Working with clinicians to ensure that they have ownership of SDM tools is critical in securing ongoing support for implementing SDM. For instance, when clinicians were involved in developing decision support materials, it was felt to be effective for securing buy-in.
- The implementation of specific SDM tools is more likely to be successful when local clinicians and patients have been involved in their design and piloting.
- Where possible, existing software and information systems should be harnessed to support SDM, such as intranets, GP and hospital software packages, and information provision in resource centres and waiting rooms.
- Effective SDM early on in a patient pathway has benefits further down the line – for example, in securing genuine informed consent, and avoiding or managing the impact of any decision regret.

## 4.4 Creating a health system that is ready for SDM

There are a number of lessons emerging from this evaluation about what is needed to support the wider roll-out and embedding of SDM across the NHS.

First, in order to support SDM, future commissioners of services will need to gain a better understanding of the following key questions.

- How to understand and measure need in relation to SDM, including which patients are benefiting more or less from SDM.
- How service contracts and specifications can be redesigned so that services purchasers understand their requirements on SDM and are measured in terms of their success in delivering it.
- How to monitor and act on the implementation of SDM across services and care pathways. This will need to include the monitoring of clear SDM outcomes.
- How to engage patients in commissioning processes that support SDM, including involving patients in the co-design of service specifications and care pathways that embed SDM.
- How to manage the performance of providers so that they deliver SDM.
- How to evaluate and assess providers and the wider health system in providing SDM.

Other changes that will need to take place include the following.

- More sustained, active and widespread awareness-raising, training and capacity-building among patients – for example, through the creation of trained patient volunteers who promote SDM and encourage patients to demand shared involvement in decisions.
- The creation of mapping tools to enable service managers and commissioners to understand how care pathways can be redesigned to support SDM and where the decision points lie.
- Training and support to patient representative groups to enable them to understand SDM and challenge providers to improve in relation to SDM.
- The development of national measures that can enable NHS managers to monitor and track patient experiences of SDM and outcomes.
- Provision of training and development programmes to support SDM, available to clinicians at all levels of the system.
- The re-development of NHS and local authority information systems such as GP and NHS trust software systems so that SDM tools and information are readily available to clinicians and to patients, through patient records.

# Appendix: Evaluation methodology

In order to achieve the aims of the evaluation, the OPM team used a theory-based approach drawing heavily on two recognised evaluation approaches. The first is the theory of change,<sup>25</sup> which propounds the importance of surfacing and testing the inherent programme theory which underpins a specific intervention, in this case MAGIC. The second is realistic evaluation,<sup>26</sup> which emphasises the importance of understanding the context in which an intervention (MAGIC) is delivered. Our approach attempted to identify the logic underpinning MAGIC, the *mechanisms* by which the MAGIC programme and associated activities might produce their effects, and outcomes that were intended as a result of the programme.

The overarching framework for the evaluation was the programme logic model, which we co-produced with the MAGIC core design team and the Health Foundation (see page 7). The model elucidates the drivers, mechanisms, activities, effects and outcomes associated with SDM. It was used as a reference point throughout the evaluation to assess the extent to which the envisaged logic of SDM has worked as anticipated, capturing any deviations in results as they arise. The model also guided the development of methods and analytical procedures, including interview protocols and the analytical framework.

The evaluation team used a range of methodologies for collecting both primary and secondary data; these methods, as well as details of the approach and the rationale, are outlined in Table A1.

**Table A1 Methods used by evaluation team to collect primary and secondary data**

Method	Detailed approach	Rationale
<b>Scoping interviews and meetings</b>	<ul style="list-style-type: none"> <li>Meetings with stakeholders from the Health Foundation involved in commissioning and supporting MAGIC</li> <li>Attended several project meetings with the Health Foundation</li> <li>Consulted key members of the MAGIC core design team responsible for delivering the programme</li> <li>Reviewed relevant programme documents</li> </ul>	The scoping phase of the work was essential to help the evaluation team understand the context of the evaluation, and for formulating the logic model, data collection instruments and analytical framework
<b>Development of logic model</b>	The logic model was developed through a co-productive and iterative approach. The team used an online system to draft and develop the logic in collaboration with the MAGIC core design team and the Health Foundation	<p>The logic model provided a template for MAGIC implementation against which the evaluation team was able to assess progress made by the programme</p> <p>The content of the model was used to determine evaluation methods and key lines of enquiry. It also informed analysis procedures.</p>

<sup>25</sup> Chen HT. (1990) *Theory-driven evaluations*. Thousand Oaks, California: Sage Publications.

<sup>26</sup> Pawson R, Tilley N. (1997) *Realistic evaluation*. London: Sage.

Method	Detailed approach	Rationale
<b>Review of programme data</b>	<p>In the first half of the evaluation, the evaluation team embarked on a review of programme data. This included:</p> <ul style="list-style-type: none"> <li>• minutes and notes of MAGIC core design team meetings and relevant clinical team meetings</li> <li>• protocols for implementation and monitoring activities</li> <li>• all tools and methods used</li> <li>• aggregated quantitative data and indicators collected by clinical teams</li> <li>• summated qualitative data from programme interviews and meetings</li> <li>• other documents as requested and agreed by the core design team</li> </ul> <p>While the team were able to collect the majority of the above data, the aggregated quantitative data and indicators collected by clinical teams were not collected</p>	<p>Collecting this data helped the evaluation team to understand programme progress and outputs, and to explore the following topics:</p> <ul style="list-style-type: none"> <li>• use and impact of primary and secondary care implementation processes</li> <li>• implementation effects on the clinical pathway</li> <li>• extent and effectiveness of clinical engagement</li> <li>• extent and effectiveness of patient engagement</li> </ul>
<b>Interviews with board-level representatives</b>	<p>We conducted a total of nine in-depth, semi-structured telephone interviews with board-level representatives such as clinical and nursing directors. This was done over two waves throughout the evaluation.</p>	<p>These interviews were particularly important for exploring the extent and effectiveness of senior management engagement</p>
<b>Interviews with managers and clinicians</b>	<p>We conducted interviews with a total of 46 managers and clinicians closely involved in implementing SDM across the two sites. This was done over two waves throughout the evaluation.</p>	<p>Interviews were critical to help the evaluation team unpack and understand the process through which SDM is implemented</p> <p>Interviews helped explore how effective the programme was at supporting SDM and transferring learning</p>
<b>Patient involvement</b>	<p>The OPM team attended PPI panel meetings in Newcastle and interviewed a small selection of patients from this panel.</p> <p>Patients were also involved in the development of the improvement stories</p>	<p>Attending PPI panel meetings and interviewing panel members allowed the evaluation team to understand how the panel worked and to assess their level of involvement and impact on the implementation process</p> <p>Patients' views were sought during the improvement story visits in order to learn first-hand about their experiences, and the benefits and challenges of taking part in SDM</p>

Method	Detailed approach	Rationale
<b>Observations of local design team meetings</b>	The evaluation team attended (mainly via teleconference facilities) 27 of the local design team meetings in Newcastle and Cardiff as non-participant observers	The purpose of this was to understand programme implementation changes, challenges and strategies, and how the concepts of SDM were embedded into clinical practice, understood, and developed over time
<b>Improvement stories</b> <i>(See the learning report <b>Implementing shared decision making</b>)</i>	The evaluation team developed a total of seven improvement stories. These looked at teams' holistic experience of SDM implementation and its impact on clinicians and patients. The improvement stories were derived from a site visit, with in-depth interviews with a range of stakeholders involved in implementation, including patients	The improvement stories provided a rich narrative of how teams experience SDM. They also generated learning that can be used both internally by the MAGIC programme and externally by the Health Foundation to promote SDM and to support dissemination across the wider health system
<b>Online survey with clinicians and managers</b>	<p>The MAGIC survey was designed to capture the views and experiences of all staff in the participating MAGIC clinical teams across the primary and secondary care settings in Newcastle and Cardiff</p> <p>OPM produced an initial draft survey, informed by existing literature on SDM. The survey was then circulated for comment to the Health Foundation and to the MAGIC local design teams (LDTs) and went through various iterations until all parties were happy with it. The LDTs ensured that the range of MAGIC programme activities included in the survey was comprehensive and that the language and wording used to describe the different elements of the programme was correct</p> <p>The survey was distributed by an invitation email that included a link to the survey and instructions on how to access a Word/paper version. It was live for two weeks. A deadline was specified and anonymity was promised. The survey invitation was sent to members of the extended teams across Newcastle and Cardiff (that is, the individual clinical team members who were invited to the various MAGIC training and support events, as described in the programme's project initiation document). Blanket reminders were sent to the teams in order to encourage participants to complete the survey.</p>	<p>The survey was used to gather clinical perceptions of progress on key elements of the programme, including:</p> <ul style="list-style-type: none"> <li>• awareness of SDM</li> <li>• impact of MAGIC on clinical practice</li> <li>• involvement in training or other awareness-raising activities</li> <li>• use and perceptions of decision support tools</li> <li>• use of monitoring and data capture tools</li> </ul>

Method	Detailed approach	Rationale
	As all completions were via the online survey, all of the closed questions were able to be 'forced', and so the quality of data submitted by each participant was high	
<b>Interviews with the MAGIC team</b>	In the final stages of the evaluation, the team conducted in-depth, semi-structured interviews with the key members of the MAGIC teams in Newcastle and Cardiff	The interviews gave the MAGIC team the chance to reflect on the process of implementation, and to highlight the learning and key insights they had developed throughout the life of the programme
<b>Analysis</b>	The logic model formed the basis of a multi-level analytical template, enabling the evaluation team to review, synthesise and integrate both qualitative and quantitative data. It facilitated the management of different data in relation to different units of analysis (eg, clinical areas, settings, etc) and thematic lines of enquiry (eg, marketing, skills training, types of decision support tool)	The analysis process was critical to understanding the overall impact of the MAGIC programme. The process we established enabled us to systematically collate, sort and analyse a range of data sets
<b>Formative learning</b>	The evaluation intended to contribute to learning and the development of MAGIC during the course of the programme. Emerging findings were fed into the programme through the production of detailed interim reports in April and September 2011. The OPM team also attended and presented interim findings at the joint clinical teams meeting in June 2011 and the formative learning event held by the Health Foundation in November 2011	The MAGIC team were keen to learn throughout the course of implementation. The evaluation contributed to the developmental process, and where possible, the core design team had access to emerging findings

Table A2 details the number of people interviewed across both sites, and the core design team (CDT) and local design team (LDT) meetings attended by the evaluation team.

**Table A2: Number of people interviewed and design team meetings attended by the evaluation team**

	Cardiff	Newcastle
<b>Interviews</b>		
Clinicians	15	20
Managers	4	9
Board level	5	4
<b>Total</b>	<b>24</b>	<b>33</b>
<b>CDT/LDT meetings</b>		
13 Oct 2010	Y	Y
17 Nov 2010	Y	Y
15 Dec 2010	Y	Y
12 Jan 2011	Y	N
16 Feb 2011	Y	Y
10 March 2011	Y	Y
13 April 2011	Y	Y
11 May 2011	Y	Y
15 June 2011	-	-
13 July 2011	Y	Y
17 Aug 2011	Y	Y
14 Sept 2011	Y	Y
12 Oct 2011	Y	Y
16 Nov 2011	Y	Y
14 Dec 2011	Y	N (due to LDT technical problem)
12 Jan 2012	Y	N (due to LDT technical problem)



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The Health Foundation  
90 Long Acre  
London WC2E 9RA  
T 020 7257 8000  
F 020 7257 8001  
E [info@health.org.uk](mailto:info@health.org.uk)

Registered charity number: 286967  
Registered company number: 1714937

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