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Behaviour change in the Welsh NHS: insights from three programmes

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Contents

Summary	2
Introduction	3
Lessons from Behavioural Science	3
Delivering Prudent Healthcare	6
Reviewing the Programmes from a Behavioural Perspective	12
Some Common Themes	17
Conclusion	21
Annex A: Understanding Capability Opportunity & Motivation	23
Annex B: Workshop Write-up	25
References	34



Summary

- Trying to change the way that a health system operates can usefully be seen as an attempt to change the behaviours of the people within it. In this report we explore how applying the insights of behavioural science can inform efforts to change health care provision, focusing on three national programmes in Wales: Making Every Contact Count, Choosing Wisely Wales, and Social Prescribing.
- All three programmes aim, in different ways, to change the relationship between patients and the health service; and specifically to improve health outcomes by reorienting health service provision towards co-production and prevention as part of the Prudent Healthcare agenda.
- The evidence base for the efficacy of the programmes suggests that they have the potential to contribute to the achievement of these aims. However, for them to do so, and at scale, requires addressing significant barriers to change; particularly the structural and cultural factors that reinforce current behaviours in the system. Such factors, from the time and resource constraints in the current system, to the way in which staff perceive their roles, act as strong counter-weights to staff and patients changing their everyday behaviour.
- Each of the national programmes reviewed places a strong emphasis on staff training programmes as the key mechanism for change. Such training can do more than impart the necessary knowledge and skills; it should also seek to address social and cultural barriers, such as perceptions of duty and professional identity. But, as programme leads recognise, on its own, training won't be sufficient.
- There is a *prima facie* case for greater alignment and coordination of these programmes, as each is seeking to make similar and related changes in the way that the service interacts with patients. Given the scale of the desired change, there would also seem to be a case for linking these three programmes to a broader piece of work which consciously seeks to identify and address the ways in which the current health system disincentivises co-production; and which builds in effective monitoring and evaluation tailored to supporting learning and change.
- The wider pressures facing the Welsh NHS make transformative change difficult to achieve. Even without these, moving to a more co-productive and preventative health service will necessarily be a long-term project. If the programmes reviewed are to realise their potential impact, they will need to be integrated into the Welsh Government's response to the recent Parliamentary Review of Health and Social Care in Wales, and form part of a package of measures designed to support co-production.

Introduction

The Public Policy Institute for Wales was asked by the Cabinet Secretary for Health and Social Services to examine how the Welsh Government might adopt insights from behavioural science to inform the development and implementation of national programmes that aim to contribute to the four objectives of Prudent Healthcare.

Prudent Healthcare is the vision for health services in Wales and its principles aim to change the way that these services interact with patients, by placing a greater emphasis on prevention and co-production. By making the public, patients and professionals equal partners in their health and wellbeing, improvements in outcomes for patients are anticipated through both greater ownership of health from patients, and reorientation of health provision towards supporting population health. It is expected that effective implementation of this approach will also lead to a reduction in ‘unnecessary’ demand for health services.

Our research considers three national programmes that in different ways contribute to this vision: Making Every Contact Count, Choosing Wisely Wales and Social Prescribing. Each aims to improve the quality and value of interactions between the public and health services in order to enable patients to take a more active role in their health.

This report presents findings from an evidence review, interviews, and an expert workshop that applied learning from behavioural science. It reflects on the common areas of learning across the behavioural change elements of these programmes and concludes with a series of considerations, not only for clinicians, but for the wider health system of Local Health Boards and Welsh Government, among other stakeholders.

Lessons from Behavioural Science

The programmes reviewed, and indeed wider attempts at encouraging changes to the way that national health systems operate, can usefully be seen as attempts to change behaviours. Traditionally, interventions that have sought to change behaviour have assumed that behaviours are largely driven by conscious and rational processes, and can therefore be strongly influenced by affecting a subject’s intentions (e.g. raising awareness or understanding of the issue). Such approaches fail to consider the extent to which behaviours can be automatic (e.g. habits and impulses) and are shaped by individual psychological or physical characteristics, as well as by the physical and social context. By contrast, behavioural science seeks to consider the full range of factors that shape behaviours, including individual lifestyle



factors, social and community influences, and wider socio-economic, cultural and environmental conditions (NICE, 2014).

Much of the recent policy interest in behavioural science has been focused on developments in behavioural economics, and specifically the concept of ‘nudge’. Sometimes referred to as ‘choice architecture’, ‘nudge’ techniques or ‘behavioural insights’, these approaches aim to change behaviour through manipulation of small environmental cues or harnessing of social norms. But these focus on only some of the range of factors that affect behaviours, not adequately capturing the potential impact of, for example, legislative or economic drivers, or the role of conscious and reflective aspects of decision making.

Professor Susan Michie and her colleagues at UCL’s Research Department of Behavioural Science and Health have developed the COM-B model of behaviour (Michie et al., 2011). It identifies three drivers which interact to produce behaviours:

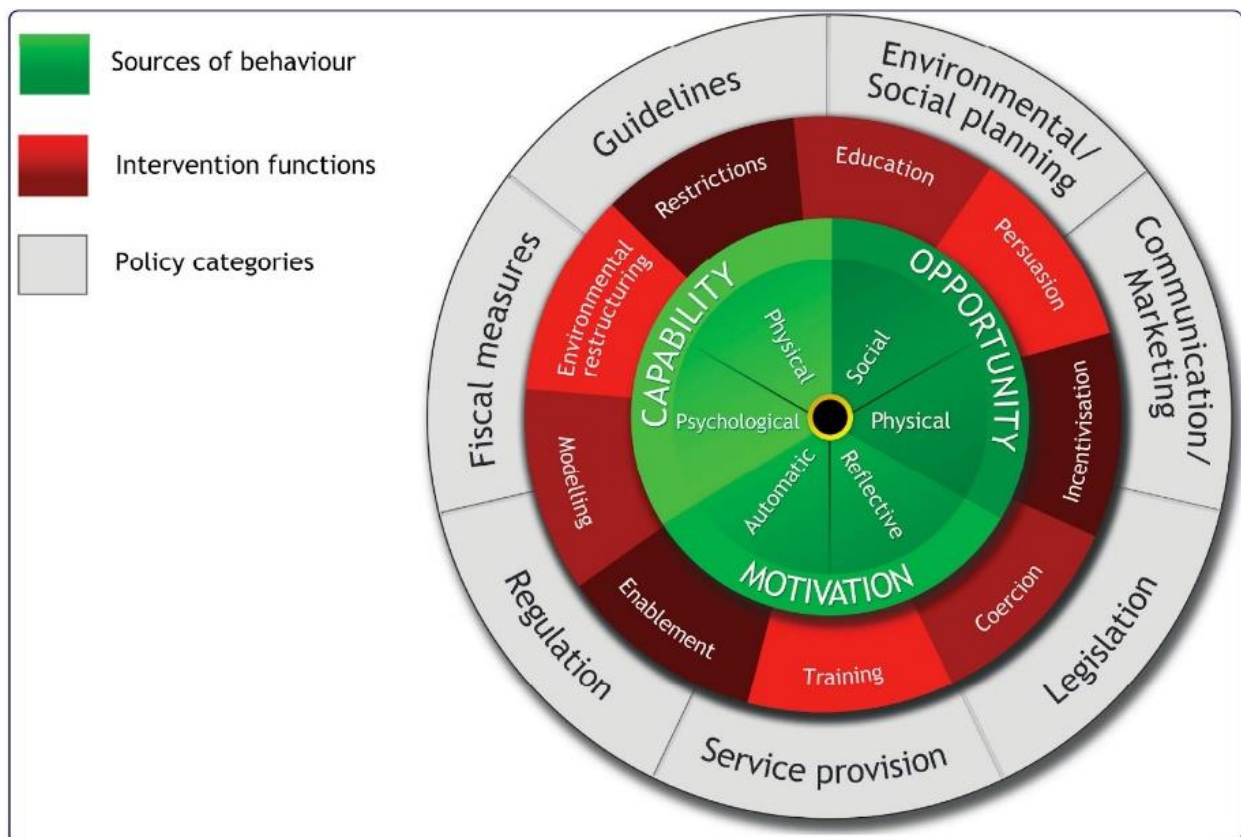
- i) Capability: psychological or physical ability to enact behaviour
- ii) Opportunity: physical and social environment that enables behaviour
- iii) Motivation: reflective and automatic mechanisms that activate or inhibit behaviour

Michie et al. argue that all three drivers combine to shape individual behaviours, and so efforts to change those behaviours must also consider and address these three drivers. Put another way, the physical and mental ability to do something is insufficient without both the motivation to act (either consciously or through habit) and an environment that supports (or at least does not inhibit) the behaviour in question (Atkins and Michie, 2013: 30).¹

When seeking to change a behaviour of a target group, it is necessary to understand which aspects of the COM-B model are acting as enablers or barriers, and to design interventions accordingly. The Behaviour Change Wheel (shown below) is a synthesised framework that presents the COM-B model alongside types of intervention and associated areas of policy.

¹ Capability, opportunity and motivation can be further broken down to fully understand the sources of an individual’s behaviour; see Annex A for further detail.

Figure 1: The Behaviour Change Wheel (Michie et al., 2014)



The COM-B model, and the Behaviour Change Wheel, are designed to be applicable to any and all behaviours and, as such, are relevant across all public policy domains, and not exclusively health. While this is a useful tool for conceptualising behaviour change, it is important to recognise the limitations of any framework.²

Nevertheless, the systematic nature of the development of the Behaviour Change Wheel renders it among the most comprehensive and conceptually coherent behaviour change frameworks. Accompanying the wheel is a taxonomy of 93 behaviour change techniques and a six-step process for identifying and designing the most suitable interventions (Atkins & Michie 2013: 32-33):

1. Select the target behaviour
2. Specify the target behaviour
3. Understand the target behaviour
4. Build the intervention

² For example, it has been argued that behaviour change programmes, in seeking to reduce complexity, can focus too strongly on changing society one individual at a time (Moore and Evans, 2017).

5. Specify the intervention's content
6. Deliver the intervention

Breaking down an intervention in this way ensures that the correct behaviours are targeted (1), that they are described as clearly as possible to allow measurement (2), and that they are understood in as much detail as possible (3). This allows an intervention to be built (4), in a way appropriate to targeting the behaviour (5), and then delivered in the appropriate context (6), for example through a face-to-face interaction, or a change in public policy.

Achieving Prudent Healthcare

The Prudent Healthcare agenda seeks to reorient healthcare provision towards co-productive patient-clinician relationships, in which patients are active partners. As a result, there is particular focus on trying to increase the patient's health literacy and this section introduces two programmes that aim to contribute to this: Making Every Contact Count (MECC), and Choosing Wisely Wales (CWW). In addition, the Welsh Government has committed to running a Social Prescribing (SP) pilot. SP is intended as a form of 'prevention'; it is a way of primary care services referring or sign-posting patients to non-clinical programmes, typically health and wellbeing services delivered outside of traditional health service provision.

All three, in different ways, aim to change the way the health service interacts with patients both to improve health outcomes and reduce 'unnecessary' demand on the NHS. Prudent Healthcare envisions that combining this approach with a prevention agenda and a focus on effective and efficient use of skills and resources should reduce variations in levels of care and prioritise care for patients with the greatest need. These are not uniquely Welsh programmes but are based on models originating either from England or outside the UK. This report however considers the design and implementation approaches being taken in Wales.

The three programmes are at different stages in terms of their development as national programmes, although all are at a relatively early stage. This section explores what each programme is hoped to achieve.

Making Every Contact Count

MECC aims to embed conversations about health and healthy behaviours into day-to-day conversations. The idea underlying the MECC programme is to take advantage of every interaction between NHS staff and members of the public, to both encourage healthier

lifestyles and signpost people to support if needed. The national programme encompasses a range of activities designed to address a series of social determinants in health, and refocus health and other services towards a more preventative service. It recognises that instilling behaviour change is not merely about providing patients with knowledge about their health and how to improve it, but must be accompanied by an understanding of the patient's own context, and encouraging them to find the most appropriate solution given their circumstances.

MECC interventions can be categorised in three levels of increasing intensity, requiring increasing knowledge and skills to deliver:

- Level 1: brief advice can be offered by everybody in the NHS (and ultimately staff across all public and third sector bodies), irrespective of time or resource. Brief advice is about raising healthy behaviours in the right way by taking the opportunities and cues that arise in day-to-day contact, and by giving consistent correct advice on the benefits of change as well as recommending an effective accessible service. It is hoped that empowering staff to engage in these conversations will not just benefit patients, but also support a culture change within the workforce.
- Level 2: brief intervention is more structured, and requires specific *skills*, knowledge and (probably) more time to perform. It adopts a motivational interviewing approach, aiming to improve self-efficacy in the patients, using shaping and brief goal-setting as other theoretical behaviour change components. It will also often involve a measurement of weight, blood pressure or lung function for example, or questions about alcohol consumption, smoking or exercise on which to base the conversation. Brief interventions are most likely to occur during contacts between the public and health professionals (e.g., GPs, district nurses), although others could be trained to develop these skills and knowledge.
- Level 3: applied behaviour change, includes motivational interviewing, cognitive behavioural therapy, motivational enhancement therapy and other approaches based on behaviour change. Unlike Levels 1 and 2, which are designed to be incorporated into routine contact, this is likely to involve a dedicated session with at least one follow up appointment. The national programme is currently less focused on level 3 interventions, as there are only small numbers of front-line staff with the opportunity to incorporate such intensive interventions to their routine role. This level of intervention and the tools and techniques within it are more routinely found in specific behaviour change services like Stop Smoking Wales, the National Exercise Referral Scheme, or local weight management services, in addition to NHS primary mental health services.

Training front-line staff to undertake brief interventions has been underway for some time, focusing mainly on smoking cessation and harmful alcohol consumption. While MECC is a national programme, each health board has a local public health team (employed by Public Health Wales), with each having a slightly different approach that suits its own requirements. The Health Improvement Division of Public Health Wales convenes a national MECC network of consultants in public health, providing opportunities for collaboration and a more co-ordinated approach to MECC across Wales.

A study of Making Every Contact Count in England (Lawrence et al., 2014) found that clinicians can be trained to support healthy behaviour change. Staff who went through the training process used more open questions and spent more time listening and reflecting than talking to (or at) their patient. The authors argue that front line practitioners at all levels of the NHS can be given training in supporting behaviour changes, and that this can become embedded in practice and culture over time (Lawrence et al., 2014). Others agree this approach can be effective in bringing about behaviour change (Lundahl and Burke, 2009). Evidence suggests that brief advice and interventions can lead to changes in health outcomes. For example, Kaner et al. (2007) found that brief interventions consistently led to reductions in alcohol consumption; Stead et al. (2008) found that brief advice had a small effect on smoking cessation; Jackson et al. (2013) found that brief advice increased motivation to lose weight. The approach being pursued by the MECC team is to apply such advice and interventions more broadly with the aim of achieving a larger impact across the population.

Choosing Wisely Wales

CWW aims to change the nature of interaction between the clinician and the patient. It has been developed in response to two insights about the status quo. The first is that many patients report that they do not feel sufficiently involved in decisions made about them; the second is that many tests and treatments are more likely to cause harm than benefit to some patients. NICE (the National Institute for Health and Care Excellence) has identified interventions that are of minimal value and will rarely improve outcomes and argues that clinicians should not do them. Choosing Wisely asks clinicians to identify low value interventions that should normally be avoided but recognises that in some cases, for particular patients, some tests and treatments may be beneficial and outcomes should be considered in terms of what is important to the patient. Choosing Wisely aims to encourage better conversations, so that the individual knowledge and experience of the patient is considered alongside the knowledge and experience of clinicians. While the clinician is the medical expert and should remain so,

patients are the expert in their own environment and culture, and Choosing Wisely looks to harness patient expertise to improve the nature of interactions, and ultimately to improve patients' health.

CWW assumes that there is rarely one answer to a problem. The evidence for the efficacy of a particular intervention will often be based on analysis of the effects on a large group of people, and within that diversity there will be people with different experiences. CWW aims to uncover these differences, to better meet individuals' needs. Patients have choices; the discussion should identify the options and together the clinician and the patient decide what is right for the patient in relation to what matters to them.

It is expected that the primary method for rolling out this programme will be face-to-face training of clinicians; principally in primary care. Training, at the time of this review, has not commenced, but the intention was that it will focus on shared decision making, with the focus on moving from traditional paternalism to partnership and shared responsibility.

The evidence is mixed as to whether changing the clinician-patient relationship has a direct effect on health outcomes. Supporting a direct effect, Kelley et al. (2014) find that a patient-clinician relationship has a small but statistically significant effect on healthcare outcomes. They argue that although it is a small effect, similarly small effects are often found for some medicines, yet they are not dismissed as a means of improving health care outcomes. Most other evidence collected by academic studies over time suggests that there is a significant and positive relationship between shared decision making and a change in health outcomes – this relationship is most likely to be associated with changing the patient's emotional and cognitive thinking, rather than directly with their health outcomes (Shay and Lafata, 2014).

Indirect effects might also occur by changing a patient's approach to their healthcare over time, improving aspects such as patient understanding, agreements on treatment, and patient adherence to treatment (Kitson et al., 2013). Improving the relationship and nature of communication between the clinician and patient might encourage patients to discuss their pain more openly and accurately, which prompts change in medication, which then improves health outcomes (Street Jr., 2013). A series of empirical studies have found that patients that are actively involved in their own health care are more likely to have regular check-ups and immunisations, attend screenings, have healthier diets and generally engage in exercise and other healthier behaviours, while patients less actively involved know less about their treatment, and are more likely to delay medical care (Hibbard et al., 2004 and 2005, Hibbard and Cunningham, 2008 and Fowles et al., 2009). Positive effects of actively involving patients in their healthcare are found with regard to both physical and mental health (Green et al., 2010 and Marshall et al., 2013). While, like many measures discussed in this review, it is not a

catch-all solution, the evidence is strong that empowering patients in their own health care improves health outcomes across a range of patients with a range of conditions.

Changing culture in clinical practice is crucial to the success of Choosing Wisely Wales. Malhotra et al. (2015) argue that doctors should provide patients with resources to show that interventions can sometimes do harm, and that clinician training should place greater priority on the risks of intervention. Patients should also be encouraged to question treatments and interventions. Analysis of the Choosing Wisely programme in the United States (Rosenberg et al., 2015) suggests positive but only moderate results. While use of some services reduced, some remained the same, and the authors suggest that there need to be additional interventions including physician communication training, financial incentives, clinician scorecards, and data feedback.

Social Prescribing

SP is intended to be a 'preventative' programme. It offers primary care services a way to refer or sign-post patients to wellbeing services, including those provided by third sector or community organisations. Advocates argue that it enables the health service to recognise and respond to the social, economic and environmental factors that contribute to peoples' health. Social prescribing is quite a broad term. Public Health Wales distinguishes between five categories:

1. Primary care referral to a link worker who can facilitate social prescription
2. Referral to community exercise programme
3. Referral to community arts programme
4. Referral to a commercial weight loss programme
5. Referral to a community-based welfare advice service

The objectives are that patients take greater control of their own health (1), which may lead to a reduction in use of NHS services (2). There are many programmes in Wales that may fall under the banner of Social Prescribing. During this study, we have spoken to those involved in running projects such as the National Exercise Referral Scheme (NERS), as well as local programmes in Torfaen, Cardiff and Rhondda Cynon Taff & Merthyr Tydfil. All present examples of where their programmes are working for the individuals concerned, although 'hard' data that they are leading to sustained behaviour change or a reduction in inappropriate use of NHS services is lacking. Comparative evidence is still required on whether SP can deliver these objectives.

Individual case studies nonetheless provide support for social prescribing in improving health. For example, Stickley and Eades (2013) found that people accessing mental health services who participated in an arts programme reported greater self-confidence and motivation, and that these facilitated more concrete outcomes such as educational achievement or entry into voluntary work. Morton et al. (2015) found that one social prescribing programme contributed to a reduction in patients' anxiety and depression. A study carried out in Bristol (Kimberlee, 2013) showed that social prescribing there had a statistically significant impact on wellbeing and exercise; GP appointments overall also reduced, although in a minority of cases they increased. There were also broader social and economic benefits, including increased volunteering in the community and beneficiaries of social prescribing returning to employment (Kimberlee, 2013).

However, these are studies of individual social prescribing projects, and more broadly there remains a lack of evidence on the effectiveness of social prescribing as a general approach. One study looked at the evidence available and found that it 'fails to provide sufficient detail to judge either success or value for money' (Bickerdike et al., 2017: 1). Part of the problem is that, rather than being one specific programme, like Making Every Contact Count and Choosing Wisely Wales, Social Prescribing is a broader term that encompasses many different programmes. Some of these programmes began recently, but others were in place long before the current focus and interest in social prescribing. This means that programmes and their evaluations have often emerged, rather than full and rigorous evaluations being carried out (Bickerdike et al., 2017).

The Scale of these National Programmes

It is important to highlight each programme's limited role within the broader NHS. They are relatively new and emergent national programmes and are restricted in terms of resource, scope and scale, all of which impacts on their capacity to influence culture and practice across the health service³.

The national Making Every Contact Count programme has limited resources (an equivalent of one full time employee), and its influence is indirect – seeking to coordinate the activity of local public health teams within the structures of the Local Health Boards. There is widespread

³ In the case of MECC and Social Prescribing, Health Boards have been operating local programmes for some time.

support for MECC, but national efforts to ensure consistency, realise the potential economies of scale, and develop frameworks for evaluation will take time to come to fruition.

Choosing Wisely Wales is also limited in scope. So far, discussions around its implementation are limited to secondary cancer treatment. It is not yet in operation, and when it is it will not be resourced as a national campaign. At this stage, it is part of an ongoing discussion about how to improve patient participation in health care. Currently, a very small team of staff (two doctors, a programme manager, a care practitioner, a project support employee) are working, largely alongside other jobs, on the programme. The objective in the longer term would be to have trainers in shared decision-making working in local health boards for one or two days a week.

Fundamental questions remain regarding local delivery of Social Prescribing. In many cases, clinician referral to wellbeing services existed well before the term “social prescribing” itself. There is nervousness as to the capacity of the third sector to provide appropriate services and divergence in attitudes as to the role of a link worker; whether they are always required, and the extent to which they should have access to patient information, such as medical records. The use of terminology, such as referral, is also debated, as a clinician can only officially refer to an accredited specialist service and other staff, such as receptionists, cannot refer. Recommending, or signposting to services however seems less directive and therefore may carry less weight than is inferred from a prescription.

This is not to undermine the role that each programme is playing in the NHS, or might play in the future. It is rather to highlight that some of the challenges they face are in part due to their scale and scope. They are important programmes that seek to change the nature of patient participation in the health service, but it is useful to place them into their proper context.

Reviewing the Programmes from a Behavioural Perspective

In October 2017, the Public Policy Institute for Wales held a workshop, inviting contributions from participants involved in the running of Making Every Contact Count, Choosing Wisely Wales and Social Prescribing. The discussions focused on analysing the programmes from a behavioural perspective, exploring the barriers or enablers to changing behaviour, and what the programme might do to combat this. This section focusses on some key messages and ideas that emerged for each programme in the context of the sources of behaviour (capability, opportunity and motivation) set out in the COM-B model.⁴ Together, they provide some

⁴ A more detailed and descriptive write-up of the workshop is available in the Annex B.

insights into potential next steps, but do not constitute a comprehensive evaluation or forward plan.

Making Every Contact Count

The target behaviour addressed in the workshop was workers in the health and social care system (and beyond) deliver simple, effective and appropriate advice and interventions to encourage health-related behaviour change across the population.

A key issue identified in the workshop was ensuring that staff across the NHS (and beyond) have the appropriate capability to deliver interventions. This involves a number of aspects. Firstly, staff need to know what problem lifestyle behaviours are, and how to identify them. This may be easier with certain conditions than others, e.g. the cues of poor mental health can be much less obvious, compared to observing someone smoking. There is then knowing when and how to raise what may be a sensitive issue. Staff need the skills to assess the appropriateness of a conversation, and tailor their approach each time. Some staff will have received guidance as part of previous professional training, but others have not, and future training will need to reflect the divergent capabilities across the service.

Training will need to recognise the difficulties in having these conversations. For example, there are cultural barriers to discussing certain health conditions. For example, workshop participants noted that they do not have a way of talking to people about obesity in the same way that they do with smoking. The language is currently geared towards seemingly abstract measures like body mass index, while smoking is more easily related to the effect on family and friends. Taking into account the emotional labour of changing such behaviour will also be helpful: staff will need to be comfortable raising difficult issues that may upset patients. Staff will also be aware of their own personal circumstances: they may share some of the behaviours they are seeking to help change in a patient, and a patient's perception of them could undermine the message and make conversations more difficult.

Participants recognised the potential perception of Making Every Contact Count as 'yet another programme'. If staff are to deliver brief interventions on a regular basis to large numbers of patients, then it needs to be an accepted part of workplace culture, and be perceived as good and regular practice. Having credible role models ('champions') in place could play a role in encouraging this new behaviour, and highlighting how it is a collective responsibility throughout the health service.

The team involved in MECC are aware of these issues, and co-ordinating current good practice across Wales in these areas will be valuable in encouraging changes in behaviour

nationally. The programme team is currently reviewing how interventions influenced by MECC are reported within clinical notes, with the aim of both collecting data on impact, and to integrate good practices instigated by MECC into professional development reporting frameworks. The ambition is that the national programme over time leads to a change in culture, however fulfilling such an ambition will inevitably be a long term goal and is likely to require enhanced resource and activity.

Choosing Wisely Wales

The target behaviour addressed in the workshop was getting healthcare professionals to have structured conversations with patients that are consistent with the principles of shared decision making.

The issue of time was discussed at length by stakeholders. Given that the cornerstone of CWW is better conversations between patients and clinicians, a key issue is whether sufficient time will be available for meaningful interaction. Patients will need time to outline their individual considerations, and clinicians will need time to talk patients through the complex issues and options that arise from that. There is a hope that this problem will solve itself as the programme is implemented: that investing time in better conversations now may lead to more efficient conversations in future. However, the time required to support patients to engage in an informed way in treatment decisions is an important consideration in the short term. Clinicians (supported by the organisations around them) will need to be able to allow extra time for conversations, recognising the hope that this may be repaid further down the line.

A running theme in discussions around achieving the target behaviour was that, while in time these conversations will be easier, in the first instance they may be more difficult. While clinicians will be trained and experienced in having conversations with patients, they will need the knowledge and skills to challenge patients, and to ask hard questions of them at times. There is also a potential emotional resistance to having these conversations, in that they can be distressing both for clinician and patient. Clinicians might also be frustrated if better, more nuanced conversations lead to inconclusive results, or they might worry that patients might make the 'wrong' decision in their view. Participants suggested that this will, in part, require greater interpersonal skills by the clinician; but also a greater recognition that the patient has a right to be the decision-maker on their own personal circumstances.

The desired shift in respective roles also connects to possible barriers of motivation. Participants argued that the norms of clinicians as experts, and patients as non-experts, still

remain. The language surrounding this is a balancing act, as the clinician is indeed an expert, but the difference is that the patient is an expert in their own circumstances. Such norms are connected to people's identities, but also beliefs about changing behaviour. Are clinicians persuaded by the evidence on shared decision making? To what extent do they see 'doing the right thing for the patient' as being in tension with, and taking precedence over, a more co-productive approach? There is then the consideration for clinicians that, even if they believe they can change their own behaviour, do they have sufficient belief in their patients to change their behaviour as well?

The behaviours being challenged are felt to be habitual. Participants reported that a paternalistic approach is embedded in many everyday practices of healthcare providers; that there can be an instinctively negative reaction to more demanding and assertive patients; and even that there is a survival instinct at play for some clinicians, with an attitude of 'I just need to get through the day'.

While it is difficult to overcome some of these ingrained habits and culture, doing so is the very purpose of Choosing Wisely Wales. Whether via evidence from the international Choosing Wisely initiative, or from ideas discussed within Wales (and at the workshop), those involved with the programme are acutely aware of such challenges, and training is aimed to address these directly. Addressing these issues will require making this training and new behaviour part of the habits and culture of the health service. While robust evidence is lacking in the specific benefits of Choosing Wisely, there is robust evidence in favour of shared decision making, and this can be utilised more effectively. This involves not just training programmes directly as part of Choosing Wisely, but also integrating shared decision making into training courses from the outset, in universities and other programmes, so that by the time a clinician is trained, they are also trained in shared decision making as a normal and good behaviour.

While the discussion in the workshop focused on the role of training, the behavioural framework emphasises that training alone is insufficient. Changing professional identities and wider organisational culture will require a range of actions. Ideas discussed in other groups included having 'champions' that embody the new approach and try to change attitudes; and reviewing the performance management framework at organisational level to create incentives for change.

Social Prescribing

The target behaviour addressed in the workshop focuses on one group of stakeholders; specifically, the propensity of the clinician (or other qualified member of staff) to refer to a

social prescriber (link worker) or directly into non-clinical wellbeing services. The discussion was therefore based on some significant assumptions about both the referral process and the efficacy of the wellbeing service.

Evidence from interviews and participants in the workshop suggests that there are clear gaps in people's knowledge about Social Prescribing. The relevant staff need to know which services are available, details of what each does and does not provide, whether or not each is appropriate, and how to refer patients to them. It appears so far that there is a distinct lack of knowledge about all of these. This obviously limits the impact that the SP programme can have. One GP practice involved in a Social Prescribing pilot scheme reported very few referrals to the social prescriber, largely because of a lack of knowledge about provision and the process and effectiveness of referring to the link worker. Giving Social Prescribing greater prominence in the NHS may be an option.

One of the causes of limited knowledge about what SP services are available and what they provide might be that there is no standard model of Social Prescribing, and no coordinating function at a local or national level. Greater coordination might help to raise awareness and understanding. It could also support the development of a framework for measuring impact. At the moment, the lack of coordination and coherence across SP activities acts as a barrier to the identification and sharing of best practice. Welsh Government has announced a social prescribing pilot focussed on mental health and has committed to providing analytical support for the evaluation of social prescribing activities in Wales, which should start to help to address some of these issues.

Participants noted that SP is not yet widely considered a standard activity of a good health care professional and that staff need regular reminders that SP is an option for patients. The programme may give the appearance to the patient of offloading responsibility to a non-medical provider, and this might be a barrier to staff referring patients. While good quality evidence could convince staff of the effectiveness of social prescribing, there is little or no robust evidence of its effective application in local settings in Wales. Further, receiving feedback, either directly from patients or via evidence from evaluations, may help to strengthen the belief that social prescribing can work; and peer learning groups were considered by participants to be potentially powerful in embedding social prescribing among staff.

SP staff will also need the interpersonal skills to convey the benefits of Social Prescribing to health care professionals, but it is not clear yet that the programme is capable of challenging the existing paternalistic culture of health care in Wales (and the UK). Triggers and prompts could also help to address this issue. For example, participants in the workshops and GPs

have noted that the use of a 'prescription pad' might be helpful in legitimising the referral. This could be combined with good news stories from Social Prescribing. These could be shared both with health care professionals in briefings, but also used in promotional material for patients.

Together, these responses highlight the need to evaluate the role of the social prescriber, the process of prescribing itself, and the programmes offered within local areas, alongside issues relating to governance and delivery.

Some Common Themes

Some points were raised by workshop participants that apply to all three programmes. These common themes highlight not only the pervasiveness of the challenges they face, but also the synergies and opportunities to optimise impact.

Culture change

All three programmes aim to change the relationship between clinician and patient, and between the service and the patient. Achieving such a change will require a huge shift in the culture within the NHS. It requires a shift in how people think about their health, but also a shift in the health system towards seeing its role as keeping people healthy, rather than only treating sickness. This means directing people towards the most appropriate services, which in some cases will be social or wellbeing services. The behaviours being promoted are not yet general practice among stakeholders. Normalising these behaviours may involve a significant shift in clinician and patient identity, so that both can be considered experts in their own right or context. To do this, staff will need to believe that such behaviour change is possible, and feel supported that it is the good and right thing to do, because each programme is likely to increase staff involvement in difficult conversations with patients.

These programmes aim to change behaviour and so NHS culture, in order that co-productive conversations about health and wellbeing are the norm, both among staff, between patients and clinicians, and right across the health service, however a recurring theme of the workshop was that the current model of health and social care, its systems, processes and 'noisy' change environment is not able to sufficiently accommodate these cultural changes. Nonetheless, stakeholders in all three programmes felt the scale of the challenge was huge – in particular arguing that the NHS is a hierarchical organisation, with both the patient and non-medical staff effectively ranked below the clinician in terms of decision-making authority. This

paternalistic culture is then combined with a strong NHS culture of rigidity: 'this is how we do things'.

Time and resources

A persistent challenge is time. Choosing Wisely Wales wants to ensure better conversations between patients and clinicians. It wants to encourage patients to reflect on their individual context, and work with the clinician to share in better decision making. That is a lot for GP to fit into a 7-10 minute interaction. Similarly, Making Every Contact Count wants to encourage more frequent and effective interactions between patients and all staff, which also take time. So even assuming the programmes can imbue clinicians and other staff with the *capability* and *motivation* to engage in new behaviours, evidence suggests more focus is needed on ensuring they also have the *opportunity* (here, the time) to do so. Encouraging staff to prioritise these conversations above competing actions given time-pressures could be done by producing and sharing better evidence of their relative value; however it seems reasonable that the responsibility for creating the opportunity space for behaviour change should not reside with NHS staff alone, but also with those responsible for creating the processes and structures within which they work. Enabling and sustaining the behaviours needed to embed the principles of Prudent Healthcare via these programmes will require additional resources to be made available for staff, both in terms of more time in the working day, or private spaces to have conversations with patients.

Scope and scale: a coherent package

Issues are compounded and ambitions are restricted by the fact that the scale of this challenge is very big, and these programmes are currently very small. Each programme could usefully make it explicit to the health service that they are occupying this space of prevention, co-production and culture change. They should do this not just individually – they are doing this already – but find a way to do this collectively for added prominence and coherence. At present, it is not clear that the resource available at the national level is sufficient to support this.

At a minimum, it would be worth exploring the feasibility of linking training. All three programmes involve, to a greater or lesser extent, an element of training. Greater alignment could help to reinforce learning, and may create efficiencies. Beyond this, there would be value in exploring further synergies between these programmes. For example, Social Prescribing could be considered a mechanism by which to respond to issues and demand for wellbeing services raised through the brief interventions of Making Every Contact Count and Choosing

Wisely Wales. Coordinating each programme's efforts so they complement and enable each other more effectively can help to further the Prudent Healthcare agenda.

Given the scale of the desired change, there is a case for making these three programmes part of a wider national programme that seeks to reorient the health service towards co-production and prevention. This would situate the three programmes within a broader and more comprehensive plan that would seek to identify and address the structural and cultural barriers.

Monitoring and evaluation

Fundamentally, while the programmes all had stated aims, none had developed an agreed theory of change to underpin their activities; although work was underway to develop one for MECC. Identifying appropriate indicators against defined outcomes and designing tools and processes to measure progress would provide coherence and a plan to commit to. A theory of change and critical path analysis would also provide a basis for monitoring and evaluation, which would provide both formative feedback on progress and areas for improvement, plus summative evidence of impact.

Monitoring programme activity, particularly the uptake of behaviours, such as staff giving brief advice, may require new methods of data collection. Integrating programme monitoring into staff inductions and professional development reporting could present opportunities to promote consistent monitoring and reinforce behaviours; the MECC programme leads are exploring this, but it could be done across all three programmes.

Workshop participants found the introduction to behavioural science useful and thought-provoking when considering their respective programmes. Consideration should be given to designing and evaluating programmes through a behavioural science lens, as it recognises that social and environmental factors play a very significant role in influencing behaviour and could be an important approach for reorienting health services towards population health concerns.

Relative contribution to population health

Once the three programmes are up and running, they may indeed be considered 'successful', however their effects on health outcomes are likely to be small, both in terms of the overall number of people benefitting and the extent of benefit. The positive effects are also likely to be indirect. None of the behaviours discussed in the workshop directly target patients. Making Every Contact Count and Choosing Wisely Wales are focused on changing behaviour in staff,



with the hope that this then encourages behaviour change in the patient. Social Prescribing aims to encourage referral to non-medical services by clinicians. In each, the potential benefit to patients is indirect.

This is not to say that they do not affect health outcomes. MECC is based on a well-established international evidence base that brief interventions through conversations can produce small but effective changes in behaviour (Aveyard et al., 2012). International experience of programmes like Choosing Wisely Wales has been mixed, but the value of co-productive relationships to health outcomes is well evidenced. The evidence base for Social Prescribing is less well developed, but there is sound theory of change, and the Welsh Government's plans to run pilots offer an opportunity to strengthen the international evidence. However, these programmes cannot be expected to influence health at a population level, rather they can only make a supporting and complementary contribution to a much broader package of interventions that must feature more potent solutions.

Even for patients who frequently come into contact with the health system, the public's interactions with health services represent only a small proportion of their life experiences. Behavioural science recognises that the public is exposed to a vast array of other influences, and that it is therefore likely that some of the most potent interventions for behaviour change lie outside the remit of the health system (e.g. regulating sugar content, healthy workplaces or changes to the planning system). This sentiment is echoed in the interim report of the Parliamentary Review of Health and Social Care in Wales (2017: 28). As a result, changing the nature of patient participation in the health service may only have a relatively small impact on population health; nonetheless this impact is potentially significant, for two key reasons. Firstly, the interaction between citizen and service offers opportunities for influence and 'teachable moments'. Secondly, co-productive relationships seek to rebalance the locus of control away from the clinician (external) towards the patient (internal), encouraging self-determination and responsibility on the part of the patient.

Therefore, while health services and individual programmes play an important role in treating people who are unwell, and represent an important touch point with the public, there are other potentially more significant influences on population health to consider. Achieving the necessary scale and pace of change in lifestyles and behaviours requires population-level change and action across a broad range of areas.

Conclusion

The three programmes we have reviewed – Making Every Contact Count (MECC), Choosing Wisely Wales (CWW) and Social Prescribing (SP) – have the potential to contribute to the Prudent Healthcare agenda, and help to realise the aspiration for the health service to be reoriented towards prevention and co-production. However, our analysis has shown that there are significant barriers to achieving the desired change in behaviours.

The value of using a behavioural perspective to analyse these programmes is that it encourages an analysis of the full range of factors that influence behaviours in the health system. Raising awareness of the value of behaving in a certain way (e.g. co-production) and developing the skills necessary to do so, are both necessary for change, but insufficient on their own. This work has highlighted the particular importance of professional identity, and the extent to which this acts as a barrier to co-production, both from the clinician and from the patient. Sharing responsibility requires both letting go of responsibility (on the behalf of the service) and taking on responsibility (on behalf of the patient). On their own, these programmes will struggle to make meaningful progress in addressing this.

Another main theme to emerge is the time and resource constraints faced by those whose behaviour is expected to change. The programmes, at present, are seen as asking for something additional to the ‘core’ work of the service. A more co-productive and preventative approach presumes a more involved interaction between service and patient than is currently possible. And, more generally, such an approach is not encouraged and supported by the structures and processes that shape healthcare provision.

Our work has surfaced some ideas about what a more comprehensive effort to support the desired changes in behaviours could include; from work to review the initial training and induction, and the performance framework for all staff; to identifying and promoting ‘champions’ who can help to reshape health service staff’s professional identities. We suggest these ideas are not simply bolted onto the existing programmes, but instead an integrated approach across all three should aim to generate the combination of *capability*, *opportunity* and *motivation* that together enable behaviour change. The dimension which is least addressed currently – opportunity – could usefully be augmented via a conscious approach to address the ways in which the current health system disincentivises co-production. Even without such a boarder piece of work, it would seem sensible to encourage greater coordination between the three programmes. It is worth emphasising that in any case, effective change will depend to identifying appropriate metrics that enable monitoring to support learning and change.



The broader context for the Welsh NHS is characterised by financial and demographic pressures, alongside a widespread recognition of the need for change. It is in this environment – what one stakeholder called “a noisy change environment” – that the three programmes reviewed are seeking to effect change. For these programmes to have the desired impact, they should be integrated into the wider reform plan being developed in response to the Parliamentary Review on Health and Social Care.



Annex A: Understanding Capability Opportunity & Motivation

The dimensions of the COM-B model – capability, opportunity and motivation – can be broken down further to give a richer understanding of the drivers of behaviour.

Capability

Capability can be understood both as physical and psychological capability. Individuals need to physically be able to perform the desired behaviour. Psychological capability has four aspects that are required to change behaviour:

- Knowledge
 - What does the individual need to know in order to do the behaviour?
- Cognitive ability
 - What decision making skills do they need?
- Interpersonal skills
 - What communicative skills do they need?
- Self-regulation
 - How do they sustain their behaviour?

Opportunity

Opportunity can be understood both as physical and social opportunity. Physical opportunity has three aspects that are required to change behaviour:

- Triggers and prompts
 - What is triggering the individual's behaviour, or what is absent that might trigger a different behaviour?
- Space and time
 - Which resources are influencing the behaviour being expressed?
- Objects, services and locations
 - What are the environmental influences upon an individual's behaviour?

Social opportunity has four aspects that are required to change behaviour:

- Peer pressure
 - How is the individual's behaviour influenced by those around them?
- Norms around behaviour
 - Is the behaviour typical?

- Credible role models
 - Are there other respected individuals doing the behaviour?
- Culture
 - What are the cultural and linguistic resources that influence the behaviour?

Motivation

Motivation has four aspects required to change behaviour:

- Identity
 - Is the behaviour linked to an individual's personal and/or professional identity?
- Beliefs about change
 - Does the individual have faith in themselves to change their behaviour?
- Habit
 - Is the behaviour a regular occurrence?
- Emotion
 - Does the person feel good or bad when they perform the behaviour?

Annex B: Workshop Write-up

Making Every Contact Count

The target behaviour addressed in the workshop was getting workers in the health and social care system (and beyond) to deliver effective and appropriate advice and interventions to encourage health-related behaviour change across the population. It was thus assumed that staff would attend training, and assumed that any brief advice or interventions undertaken would have positive outcomes.

Capability

There are many aspects relating to the programme that workers in the health and social care system need *to know* to deliver effective and appropriate brief advice and interventions. Participants noted that staff would need to know what problem lifestyle behaviours are, and how to identify them. This may be easier with certain conditions than others; for example, smoking may be an easily identified problem behaviour, but it could be more difficult for issues relating to obesity or alcohol. This also requires specialist knowledge of how to deliver a brief intervention effectively, and knowledge of which services and resources to which people can be signposted. Finally, staff need to know the remit and potential limits of their intervention. Brief advice/interventions are quite specific, and maintaining brevity is important.

Related to *knowledge* is the *cognitive* ability to carry out the behaviour. Assuming that staff have the knowledge to deliver the advice/intervention, they then need to know when and how to raise the issue. They need the skills to assess the appropriateness of their conversation, and tailor their approach to each individual interaction. They may also need certain *interpersonal skills* for which their formal job training has not previously equipped them. They need to show empathy with the patient, and situational awareness to be able to turn difficult conversations into productive change in behaviour. These can all be difficult, and require *self-regulation* to be able to implement brief advice and interventions on a regular basis.

Opportunity

Staff need the appropriate *triggers* and *prompts*, and these might not be evident throughout the health service. For example, some staff may see notices in the restroom that others do not see, or some staff may receive useful emails while others do not. Brought together, some staff may have the appropriate triggers to continually perform a behaviour, while other staff

may be able to get through their day without being prompted to enact a particular behaviour at all. This analysis also recognises that Making Every Contact Count is an extra responsibility that is competing with other commitment in their core role, and so *space* and *time* is a potential barrier. Staff may not have the time to enter into a conversation while performing other tasks, and the space where they are in interacting may be inappropriate for a conversation about a patient's health. Staff will also need the appropriate environment, namely the appropriate *objects*, *services* and *locations* around them, to enact the behaviour. This may involve the provision of helpful leaflets for patients, contacts for referral services, or more generally having the right resources to hand.

Peer pressure may be an issue, in that one member of staff may have everything in place to perform the behaviour but is surrounded by colleagues who undermine it. However, the inverse is true. There is great potential for staff to collectively encourage each other to give brief advice and interventions. This will help to encourage *norms around behaviour*. Giving brief advice and interventions should be not just general practice but also good practice, as part of a recognition that this is a collective responsibility. *Credible role models* could play a role here. If there are people within the service that staff respect and trust who are carrying out the behaviour, this can help to foster the behaviour as good practice.

The issue of *culture* is a broad source of behaviour in itself. Participants noted that brief advice and interventions need to be part of the workplace, and accepted as the way that things are done. Barriers to this may be a culture of 'yet another programme', which then almost provides permission for it to be ignored, or the potentially inaccurate perception that this behaviour is already happening. There is an issue of the language around change management. There are also cultural barriers with certain health conditions. For example, on obesity specifically, participants said that they do not have a way of talking to people about the impact of obesity in the same way that they do with smoking. The language is currently geared towards seemingly abstract measures like body mass index, while smoking can relate to the effect it has on family and friends.

Motivation

Participants noted that the programme was not perceived as part of colleagues' professional *identity*. For example, some workers may not be directly involved in health and social care, such as hospital porters or job centre workers, but may be asked to have these conversations. Related to this are staff's *beliefs about change*. There is a need to believe that they can make the change in behaviour, and that they are capable of doing brief advice and interventions effectively. They also need to believe that it works, and that it can improve patient health.

Participants argued that people are not convinced yet about the efficacy of the programme, its value relative to other conversations they could have with patients.

There is also an issue about whether the current or changed behaviour is or can become *habitual*. For example, a porter may be requested to discuss smoking cessation with a patient, but their *habitual* behaviour may be to join the patient for a cigarette. If the current behaviour is habitual, it can be very difficult to change. There are also *emotional* considerations. Staff need to be comfortable raising difficult issues that may upset patients; these are difficult conversations to have, and staff will need to be willing to face negative reactions. Staff are also aware of their own personal circumstances. Their own behaviours and the patient's perception of them could make conversations more difficult.



Choosing Wisely Wales

The target behaviour addressed in the workshop was getting health care professionals to have structured conversations with patients that are consistent with the principles of shared decision making. It is assumed that they will undertake training, and that shared decision making is effective in improving patient outcomes.

Capability

There are a number of issues that staff will *need to know* in order to have better conversations. They need to know why shared decision making can improve patient health, as well as why certain interventions are either of no/low value or actively do harm. Knowing the role of communication in influencing the patient's health care options is important. They then need certain *cognitive* skills alongside this. They need diagnostic skills. While for many clinicians this is a core capability, for others it may be a new process. For all staff, they will need the skill to share a particular decision with a patient. This relates to *interpersonal skills*. There is a need to avoid appearing paternalistic, and they need to be able to listen to patients as they set out their individual circumstances. They also need to be able to encourage the patient to do this more, and then be empathetic with their considerations. They will also need to recognise the situational nature of clinician-patient interactions. Shared decision making may not always be the correct approach. Staff will need the skills to adopt contextually appropriate approaches. Finally, staff will need to be *self-regulatory* in order to maintain these skills as they go on through the day/week/month. They need to repeatedly challenge the idea that they cannot let go of any responsibility.

Opportunity

Participants discussed whether there would be *triggers or prompts* for staff. For example, will there be visual displays in the surgery? Will there be a pop-up screen to question if the interaction has suitably documented the patient's considerations? There is also the issue of patient passivity: the clinician might turn up ready to share decision making, only to be deflated by a passive patient who wants to cede all authority.

Considerations of *space* and *time* were also addressed by participants. Given that the cornerstone of Choosing Wisely Wales is better conversations between patients and clinicians, a key issue is whether sufficient time will be provided for a meaningful interaction. Patients will need time to outline their individual considerations, and clinicians will need time to talk patients through the complex issues and options that arise from that. Clinicians

(supported by managers) will need to allow that extra time assured that such investment will be repaid by greater efficiency further down the line.

The *objects*, *services* and *locations* surrounding the clinician are also important. Participants noted the environment being one of targets and guidelines, and that this would be perceived as yet one more initiative. The programme will also need to sit alongside more resources for patients, so that they can be more informed. Will there resources for patients on the benefits of the programme? Resources to educate them on the different options open to them? Will other services be ready to support patients if they decide to use other health and social care services?

Peer pressure may be an issue, but again provides an opportunity to encourage staff to collectively get on board with the programme. It also relates to whether the programme can become a *norm*. Is everybody else in the practice or workplace doing the programme, and is sharing decision making with the patient generally regarded as good practice? Participants noted that the relationship between a clinician and a patient is a hard one to change. *Credible role models* can be important in advancing behaviour change, but there is potentially limited opportunity for staff to observe 'good interactions', as it is an individualised interaction and profession. There may be other ways that role models can be integrated, either through campaigns or through communication between staff.

The broader *culture* surrounding the programme was discussed at length by workshop participants. They argued that the NHS is a hierarchical organisation, with the patient ranked below the clinician in terms of decision-making authority. This paternalistic culture, they suggested, is then combined with a strong NHS culture of rigidity: 'this is how we do things', and Choosing Wisely Wales is aiming to challenge that. It will take a concerted effort for Choosing Wisely Wales to become part of the culture of the organisation. Participants noted that special consideration needs to be given to those only working temporarily with some patients. For example, locum doctors will have little chance to get up to speed with patients' individual concerns, and may just want to get the job done and go home.

Motivation

Relating to *identity*, participants argued that the role of clinicians as experts and patients as non-experts still remains. If successful, the programme can challenge this barrier. One observer argued that balancing language is important, as the programme is still suggesting that the clinician is an expert, but that the patient is an expert in their own circumstances.

Participants also agreed that job titles betray a hierarchical structure, in that some staff members may be less appealing for a clinician to refer on to compared with others.

With regard to *beliefs about change*, participants highlighted the importance of the clinician believing that they could share decision making and authority with the patient. Are they persuaded by the evidence on shared decision making? Many members of staff might think that they do this already, which may make it difficult to encourage behaviour change. There is then the consideration for clinicians that, even if they believe they can change their own behaviour, do they have sufficient belief in their patients to change their behaviour too?

Changing behaviour will involve changing *habits*. Participants questioned whether clinicians currently decide on behalf of the patient as a matter of course. As noted before with regard to *culture*, some noted that paternalism is habitual. Phrases such as 'I want to help' and 'how can I help' are commonplace, as well as an instinctively negative approach to more demanding and assertive patients. Some participants even noted that there is a survival instinct at play here, with an attitude of 'I just need to get through the day'. It will be difficult to brake such an ingrained negative habit.

Finally, participants discussed the role of *emotion* in behaviour change. Some argued that clinicians have an emotional attachment to patient outcomes, and worry about them outside of work. There is potential for this to be changed by increasing patient participation. However, there may be other emotional barriers. There is a potential emotional resilience to having difficult conversations and giving 'bad news'. There was a recognition that honest conversations can be quite distressing. There is also the potential for some frustration as better conversations might lead to inconclusive results. The treatment might drift in the initial stages as patients go away and think about their issues in more detail. Clinicians may also worry that patients might make the 'wrong' decision. Participants also argued that some clinicians have a fear of litigation, as while there is shared decision making, there may not be shared accountability.

Social Prescribing

The target behaviour addressed in the workshop focuses on one group of stakeholders; specifically, the propensity of the clinician (or other qualified member of staff) to refer to a social prescriber (link worker) or directly into non-clinical wellbeing services. The discussion was based on the assumptions that:

- the referral process works and is reliable;
- the function of a social prescriber/link worker is effective; and
- that the wellbeing services are effective e.g. they are resourced, have capacity, and the services they provide are appropriate and work to support and improve the wellbeing of patients.

Capability

Participants noted that staff need to know the process for referring to a link worker. If no link worker exists, what wellbeing services are available, detail of what they do and don't provide, whether or not they are appropriate for the patient and how to refer into them. . Staff will need certain *cognitive* skills to identify and better understand the root causes of a patient's health issues. For some staff, this will be a skill they will have developed over years of professional training, but for others who do not have a medical professional background this may be a new skill.

Staff will also need *interpersonal skills* to be able to ask the appropriate questions to diagnose the broader influences upon a patient's health. They then need to be able to succinctly explain what social prescribing is, and encourage the patient to take up the referral without appearing to offload responsibility. They need to be able to convey that social prescribing will help, and effectively communicate the value of shared decision making. Finally, staff will need to continually practise social prescribing to make it an appropriate option. This may require targets at an individual or practice-level.

Opportunity

There are lots of opportunities for *triggers* and *prompts* for social prescribing. Staff could be reminded via briefings at staff meetings or newsletters, and a particular 'social prescribing pad' could legitimise the referral. It could also help to plan out next steps. Patients themselves could be a trigger, if they are in turn triggered by promotional material. Good news stories could be shared in a practice or clinic.

Space and *time* are important considerations for social prescribing. Time will be needed to engage in conversations to diagnose the broader influences of health, as well as time to become familiar with the range of services available in the local area, and the different processes for referral. Staff may also need a private space to discuss social prescribing with patients if they do not currently have one, for example, receptionists may be involved in referring to the social prescribing link worker. Finally, the *objects*, *services* and *locations* that make up the environment around staff are important. Staff will be in a better position to socially prescribe if patients have adequate resources to understand the programme, and decision-making aids and toolkits may be useful for staff.

As well as the physical opportunities that enable behaviour, social opportunities are also crucial. *Peer pressure*, *norms around behaviour*, *credible role models* and *culture* are all important in this context. The workshop asked participants to consider where these issues might not present an opportunity at the present time, or what might be a barrier to enabling the behaviour.

With regard to *peer pressure*, colleagues within the clinical (and parallel) setting will need to be on board with social prescribing. If some clinicians or other members of staff are less supportive of it, those who are in favour may feel undermined or less minded to change the behaviour. The programme also needs to become the *norm*: lots of people need to be doing social prescribing, and it needs to be generally known and accepted as good practice. This will be easier if it is generally recognised that social prescribing can tackle the broader influences and determinants of health. *Role models* could be important in this objective, and team leaders need to be on board to model the changed behaviour and encouraging take up of the programme. This could be done by showcasing staff and patients who are doing social prescribing effectively.

Finally, the broader *culture* was discussed by the workshop participants. They noted that the existing paternalistic culture of health care needs to change, in which the clinician is the expert, and social prescribing may be perceived as offloading. The patient exception that they can turn up and ‘just get a pill’ still pervades and needed to be challenged. Social prescribing needs to become part of the departmental culture as a way that things are done.

Motivation

The final set of behaviour sources refer to reflective and automatic mechanisms that can activate or inhibit behaviour. This may take the form of *identity*, *beliefs about change*, *habit*

and *emotion*. The workshop asked participants to consider where these issues could be a barrier to changing behaviour.

Identity may be a barrier to social prescribing, as clinicians may see their role as attending to the patient themselves, rather than referring them to a non-clinical service. Participants noted that it is not yet widely recognised that a good health care professional helps patients by socially prescribing. It was noted that it needs to be seen as part of the clinician's job and responsibility to socially prescribe. Staff also need to *believe* that referral to a social prescribing link worker and wellbeing services is a responsible action, and that it works. It is one thing to know that the evidence is there, but it is another to be convinced and persuaded by it. Receiving feedback, either directly from patients or colleagues, or evidence from evaluations may help to strengthen the belief that social prescribing can work. Peer learning groups were considered influential and potentially powerful in embedding social prescribing.

It is unclear if social prescribing might become a *habit* among staff. Some participants noted that writing a prescription is habitual for clinicians and, echoing the *triggers* and *prompts* discussed earlier, a social prescription pad or medical record system pop-up may be helpful. Finally, there was a discussion as to whether social prescribing will elicit positive or negative emotions among clinicians. Some suggested that clinicians may experience relief at having access to a holistic and appropriate alternative for their patients, but others argued that clinicians might find it difficult to pass on their patients to a non-medical service.

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