Realising the Value

Empowering people, engaging communities

Making the change

Behavioural factors in person- and community-centred approaches for health and wellbeing

Report

March 2016

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About this report

This report explores the behavioural science theories that suggest new ways of enabling people and communities to take a more active role in managing their own health. These new approaches may help realise the vision set out in the Five Year Forward View.

This report provides an accessible introduction to the theories of change behind the action-focused guides that will also be published as part of the Realising the Value programme. It is aimed at policymakers, commissioners, service designers and organisations working to promote more person- and community-centered approaches for health and wellbeing.

It was written by Hannah Burd and Michael Hallsworth, The Behavioural Insights Team.

We hope you find it useful.

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Introduction

This paper forms part of the first series of outputs from the Realising the Value project, a collaboration between the Health Foundation, Nesta, Voluntary Voices, Newcastle University, and the Behavioural Insights Team. Realising the Value makes the case for adopting person- and community-centred approaches in the UK's healthcare system. A key objective of Realising the Value is to change the relationship between citizens and the health system from one of passive patient to active participant.

This is a broad topic. The report *At the heart of health: Realising the value of people and communities* was published by consortium partners in February and provides an overview of the existing evidence base with a particular focus on the potential benefits of adopting person- and community-centred approaches. This paper takes a different tack. It starts from the principle that person- and community-centred health and care approaches require a certain set of behaviours, therefore increasing the impact of these approaches requires:

1. Identifying the relevant behaviours (**see Box 1**).
2. Understanding the drivers of these behaviours and the barriers to achieving them.
3. Proposing evidence-based ways to facilitate these behaviours.

This paper is aimed at the second requirement.[1] It presents five broad factors that have been shown to influence engagement and self-management behaviours, and suggests how they can be targeted in order to increase such behaviours. These factors all emerge from robust studies on what influences behaviour. However, they are not the products of a systematic review of the literature on person- and community-centred approaches to health and wellbeing: we have made two deliberate choices that shape the content of this paper.

Firstly, we have taken the view that our target audience wants to put theory into practice (rather than rehearsing theory for the sake of it). Therefore, we have selected factors or concepts that can be communicated and acted upon easily. We have also drawn on interviews conducted during the summer of 2015, with 12 champions of person- and community-centred approaches, to inform the focus of this paper and to ground it in practice. Several of the case studies featured in this paper were identified during this interview process.

Secondly, we have drawn on both health and non-health examples, in order to bring new perspectives to the field. There are many existing reports on increasing self-management in health and we do not wish to duplicate their content. The examples cited from outside the field of healthcare each require a comparable change in behaviour (for example, learning how to do something new in adult education or overcoming the challenge of searching for a job). We believe that looking to other sectors will offer new routes to realising the value of people and communities in a health and wellbeing context.

Finally, we recognise that we are focusing only on a single aspect of person- and community-centred approaches (**behaviour, see Box 1**), at the expense of others, such as educating and changing attitudes. We touch on these aspects in the following report, but only if there is clear evidence that they result in changes in behaviour. We believe that this focus on behaviour will bring results.

BOX 1 • What do we mean by 'a behaviour'

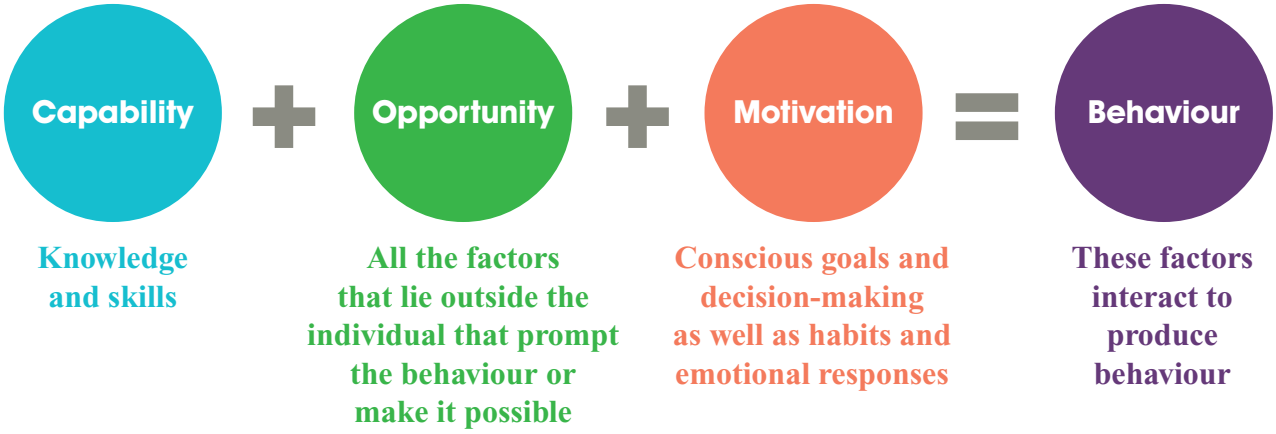
You will notice that we tend to refer to 'a behaviour' in this paper. This is because we find it useful to be very specific when trying to disentangle the complex web of factors that make up person- and community-centred care activities. For example, when considering how to increase participation in health and care we could mean one of the following behaviours (and many more like them):

- A person with a long-term condition takes a brisk walk three times a week.
- A GP regularly refers their patients to a trusted health coach.
- A mental health nurse helps their service users identify which local peer-support group would suit them best, and calls them a few days later to help in case they had any problems attending.
- Two neighbours catch a bus together to their community allotments each week where they volunteer. When one becomes unwell, he has his neighbour's contact details handy in case he needs something picked up from the pharmacy.
- A health commissioner shadows volunteers at her local befriending service once a quarter. She can now confidently describe the value of the service to her peers.

Our approach, therefore, is to focus on the specific behaviours that in combination make up 'self management' or 'person- and community-centred approaches'. We believe that enabling these behaviours in a focused, bottom-up way is an effective route to achieving the higher goal of Realising the Value.

Understanding behaviour

Researchers have identified three main components that need to be present for behaviour to occur: capability, opportunity and motivation:[2]



Within each category, different factors may be present, making a behaviour more or less likely to happen. The rest of this paper uses the three categories in the formula to discuss different factors that can drive greater participation in care:

Category	Capability	Opportunity	Motivation
Factor	1. Growth mindset, self-efficacy and 'grit'	2. Removing friction costs	4. Intrinsic motivation
		3. Social connections	5. Goal-setting and feedback

Factors leading to greater involvement in care

Factor 1: Growth mindset, self-efficacy and 'grit'

This section considers three closely related ideas. Mindset theory, self-efficacy and the concept of 'grit' each relate strongly to capability, both in terms of what someone thinks they are capable of, and, in turn, what they prove to be capable of. We begin by discussing mindsets.

Mindsets are beliefs about a person's basic qualities. People's mindsets can roughly be divided into 'growth mindsets' and 'fixed mindsets'. People with a fixed mindset see their (and other people's) basic abilities as unchangeable, whilst people with a growth mindset view capabilities as something that can be developed.

Decades of research by psychologist Carol Dweck and her colleagues have investigated the impact of mindsets on a person's success, across education, work, social relationships and health.[3] They find that a growth mindset enables people to be more resilient in the face of setbacks and feel more positive about putting effort into overcoming adversity. A person with a fixed mindset may feel like they inhabit a 'world of threats and defenses' against which their personality, inborn traits, and intelligence are incapable of putting up much resistance.[4] In contrast, someone with a growth mindset will see themselves as a 'work in progress,' capable of adapting as they go through life.

These are important observations for people with long-term conditions and health practitioners alike. It is a well-rehearsed fact that whilst people spend a handful of hours a year with health professionals, they care for themselves 24/7.[5] Thus the mindset which people have as they manage their health has implications for coping with and moving on from inevitable crises.

People with long-term conditions face the challenge of learning how to build many new tasks into their daily habits (**Box 2**). A growth mindset is a key enabler of learning new and difficult things. People who approach activities such as self-management education or peer support with a growth mindset are likely to reap more benefits from these activities than those who do not see themselves as capable of change.

BOX 2 • Tasks a patient with chronic disease may have to be able to perform[6]

- Correct medication usage.
- Exercise.
- Weight loss.
- Appropriate food selection.
- Stress management strategies.
- Pain and other symptom management.
- Behaviours that improve symptoms or slow disease progression.
- Accurate self-diagnoses, data analysis, and decisions such as testing blood glucose and adjusting insulin levels if diabetic.
- Modified personal care, household and community mobility activities.
- Adjustments to new social and economic circumstances.
- Pertinent communications with physicians, family members, and other caregivers.
- Modifications of his or her living and work environment, as well as valued activities.

Several studies also identify that practitioners' mindsets - how practitioners perceive people's capacity to adapt and grow - can affect their interactions and resulting outcomes, particularly when those practitioners occupy a guidance role. For example, managers with a growth mindset are more likely to give quality coaching to employees to help them improve performance at work.[7]

In a study on the factors contributing to primary care clinicians' decisions to spend some appointment time discussing lifestyle risks with patients (smoking, poor nutrition, excessive alcohol consumption, and physical inactivity), researchers identified that clinicians tended to pass through an 'is it worth it?' phase.[8] If clinicians question the potential for their patients to change, it is more likely that (given time pressures) clinicians will decide in that moment not to engage in prevention discussions, even when they accept the evidence that reducing lifestyle risks is vital for maintaining health.[9] Ultimately, this means that some patients receive encouragement to change unhealthy lifestyle behaviours while others do not.

Importantly, growth mindsets can be taught. In the coaching study described above, researchers found that managers with 'fixed' mindsets were more likely to be able to suggest a higher number of quality coaching ideas that would enable their employees to perform better, after a 90-minute video trained them in growth mindset approaches.[10] **See Box 3** for another example.

BOX 3 • Teaching maths to 'non-maths people'

Researchers at a large American adult education institution wanted to see whether it was possible to improve the performance of a group of underprivileged students who had struggled with maths at school.

At the start of term, half of the students (the 'growth mindset group') undertook an online lesson where they read an article about the brain's ability to change as a result of putting effort into a task and trying new strategies if their first approach fails. It cited real neuroscientific findings of how students' intelligence grows through practice. Students then wrote a summary in their own words and wrote advice based on these theories to another hypothetical student who was becoming discouraged.

The other half (the 'control group') undertook an online lesson that taught facts about memory and the brain, but did not mention that intellectual ability is malleable. By the end of the course some months later, the drop-out rate halved in the growth mindset group (to less than one in ten). In the control group one in five students had dropped out.[11]

The importance of mindset is already central to health coaching and asset-based approaches. Where practitioners see patients as capable of adaptation and change, it is more likely that care consultations and plans will become more person-centred. This attitude (whether inherent or taught) will be necessary to allow the power to shift from 'all knowing practitioner' to 'patient as equal partner.'

Self-efficacy is a closely related concept to mindsets. Where mindsets focus on understanding cognitive or thought processes, self-efficacy focuses on how those cognitive processes translate into behaviour. The concept of 'grit' also enables us to consider how desirable behaviours can be sustained over the longer term. In combination, these theories are all relevant to the promotion of both disease-preventing and health-promoting behaviours.

Self-efficacy is a belief in one's ability to complete challenging tasks, achieve goals and cope in spite of obstacles.[12] Having high self-efficacy or 'grit' describes the determination to persevere at this over long periods. [13]

Self-efficacy can be built through experiences of several small personal achievements. This bolsters the confidence required to overcome obstacles as they present themselves. In turn, this generates a more general sense of personal mastery that equips people with greater confidence next time they face challenges. The opposite can also happen, whereby repeated perceived failures make it harder for someone to 'bounce back' from adversity. Indeed, where this happens, people may build up a level of anxiety associated with personal challenges.

The theory also notes that people learn from others' experiences as well as from their own. This has direct relevance to peer-learning programmes. People who have developed a strong sense of confidence in managing a health condition can be very credible role-models and supportive problem-solvers to people who are still developing mastery over their health.

These theories have been successfully applied to health,[14] patient activation[15] and parenting programmes (see Box 4). Where the same principles have been applied to health programmes for people living with a variety of chronic conditions, impacts have included increased exercise rates, improved self-rated health status and significant reductions in emergency and outpatient visits.[16]

BOX 4 • Baby steps

Practitioners who work with disadvantaged families as part of the Family Nurse Partnership celebrate small successes with young parents on a one-to-one basis over the first two years of a child's life. The aim is to build parenting confidence and, in turn, positive environments for children to grow up in.[17] Successful baby changing and breastfeeding in the first weeks after birth can strengthen the confidence to give up smoking and enroll in professional courses later.[18] This all adds up to sustained better outcomes for both children and parents including:

- Decreases in hypertensive disorders and smoking during pregnancy.
- 56 per cent reduction in A&E attendances for childhood injuries.
- Better academic achievement in the first six years of primary school.
- 28 per cent reduction in mental health problems amongst children at age 12.
- Greater maternal employment.

In terms of cost effectiveness, the costs of the programme are recovered by age four for the highest risk families in US studies.

As well as being used to help people cope once a long-term condition has developed, the insights from mindset and self-efficacy theories can help develop the determination or 'grit' to reduce the risk of developing a chronic disease in the first place as Box 5 describes. That a growth mindset can translate into the grit and resilience to get back on to the difficult path to changing and sustaining behaviour is a promising finding. Where these theories are incorporated into the design of person-centred approaches, such programmes are more likely to result in persistent positive effects.

BOX 5 • Buffering against behavioural bumps in the road

In one study[19] researchers experimented with sending bi-weekly emails to dieters randomly assigned to one of three categories:

1. One group received 'growth mindset' messages stressing that weight is changeable and that with effort people can successfully lose it.
2. A second received emails containing with lifestyle tips for how to lose weight.
3. A third group received emails with no information regarding body weight.

All three groups were also asked to report the number and severity of 'setbacks' that they experienced in sticking to their diets over a 12-week period. Setbacks have a strong impact on behaviour. Other studies have repeatedly identified the presence of a 'what the hell' behavioural effect, whereby dieters disengage completely from working towards their goals after a diet lapse.

The study found that the first group was not more likely to lose weight than the second, but it was more likely to maintain weight loss after severe setbacks.

Factor 2: Removing friction costs

Seemingly small increases in the effort ('friction costs') required to perform a behaviour can make a surprisingly large difference to whether that behaviour takes place.[20]

A person's opportunity to make changes can be determined by big things: socio-economic status, employment prospects, where they live, and so on.[21] But it can also be affected by paying attention to the small barriers that get in the way of new, healthy behaviours.

A consistent finding across behavioural research is that reducing even apparently small barriers to accessing a service can have a surprisingly large effect on take-up. In one study involving thousands of secondary school students, researchers wanted to understand why university application rates remained persistently low amongst those who were eligible for financial aid to support them through higher education.[22] They gave one randomly-assigned group of students the application for financial aid forms pre-filled with basic information that was available via their parents' tax returns (e.g. social security number). This group also received a ten minute meeting with a tax professional to help them fill in the remaining sections and compute the amount of financial aid they were eligible for. To reduce friction cost even further, they also had the chance to submit their application form then and there at the end of the appointment. A second group were provided with information about financial aid and calculations of the amount they may be eligible for, but had to complete the form and post it themselves. A control group received a generic brochure only with information about the existence of financial aid for low-income background students.

This study found that students in the second group who received targeted information were no more likely to submit their forms than the control, whereas there was a 40 per cent increase in submissions from the first group. This translated into an increase in the proportion of students enrolling at university from 26 per cent amongst the control group to 34 per cent amongst those who received pre-filled forms and assistance to file them. 'Friction' in this context came from the difficulty of pulling together lots of disparate official information.

Making care truly person- and community-centred will mean that commissioners, policymakers and practitioners in charge of creating supportive services need to design out 'friction' from their services wherever possible. This means accounting for the difficulty of travelling somewhere if a long-term condition makes that challenging or public transport links are poor, or the difficulty of referring a patient to a service if it requires lots of computer log-ins and form-filling. Interviews held with commissioners and wellbeing managers as part of the Realising the Value programme highlighted two innovative ways of reducing friction costs for staff (**Box 6**) and service-users (**Box 7**) alike, which have ultimately enabled more people to access the services they need in a timely way.

BOX 6 • Back to basics - social prescription pads[23]

Horsham & Mid-Sussex Clinical Commissioning Group (CCG) wanted to find a way to link people up with holistic, health-promoting activities tailored to them in the simplest and quickest way possible. Together with their District Council's Health and Wellbeing Teams, the CCG created easy-to-complete paper pads that look similar to traditional prescriptions and distributed these to anyone in the local area who might have contact with a patient and identify a need for a 'more than medicine' response. Now receptionists, nurses, GPs, the police, paramedics and others can direct people to social activities (that promote exercise, reduce social isolation or support people to limit alcohol intake, stop smoking or lose weight) with a simple paper 'prescription'. This slip provides people with a number to call, after which they receive motivational interviewing over the phone and signposting to the most appropriate local social prescribing service for them.

BOX 7 • Removing friction costs on the way to wellbeing[24]

Doncaster Borough Council's Wellbeing Team used their strong local knowledge to spot opportunities to connect neighbours up who might wish to try out the same wellbeing activities. They realised that there were four people living within a few streets of each other who had all expressed an interest in trying out some gentle activities to keep up their fitness and resilience. The Wellbeing Team funded a nominal £50 to cover the cost of sharing a taxi between their homes and four different classes (including an exercise group, an art and craft group and other activities on offer locally). At the end of the month-long trial, two decided to continue attending the same class and all were satisfied that they had been given choice and opportunity.

Factor 3: Social connections

Social networks within communities create 'social capital' meaning that people are richer in support, reciprocity and knowledge sharing across social divides.[25]

Social capital and reciprocity are important theories underpinning the case for enhancing peer support and group activities for community development. Connecting to others, receiving support when needed and giving back at other times are strongly linked to experiencing a sense of wellbeing and buffering against mental ill health.[26]

In practical terms, people who have more social connections are more likely to receive timely help in order to cope in a crisis. They are also less likely to be lonely and have better health outcomes as a result. Loneliness is associated with a range of poor physical and mental health outcomes. One of the reasons for this is thought to be because loneliness makes it harder for us to control our behaviour, making drinking to excess, exercising less and self-destructive habits more common. Researchers have found links between loneliness and stress, negative impacts on the immune and cardiovascular systems and difficulty sleeping (which itself is known to have the same metabolic, neural and hormonal regulation effects as ageing).[27]

Supporting and investing in social connections could therefore have positive results for health. Enabling people with long-term health conditions to continue to take part in a variety of reciprocal relationships is an important counterbalance to the social isolation that can accompany disability.[28] Norms of reciprocity within a person's social network can become strained by the onset and ongoing demands of living with a chronic condition. This can lead to discomfort related to the fear of overburdening or becoming indebted to others.[29]

It is these observations that explain why providing support to others (e.g. peers with the same health condition) can be a life-enhancing intervention for both support recipients and support givers.[30] It is

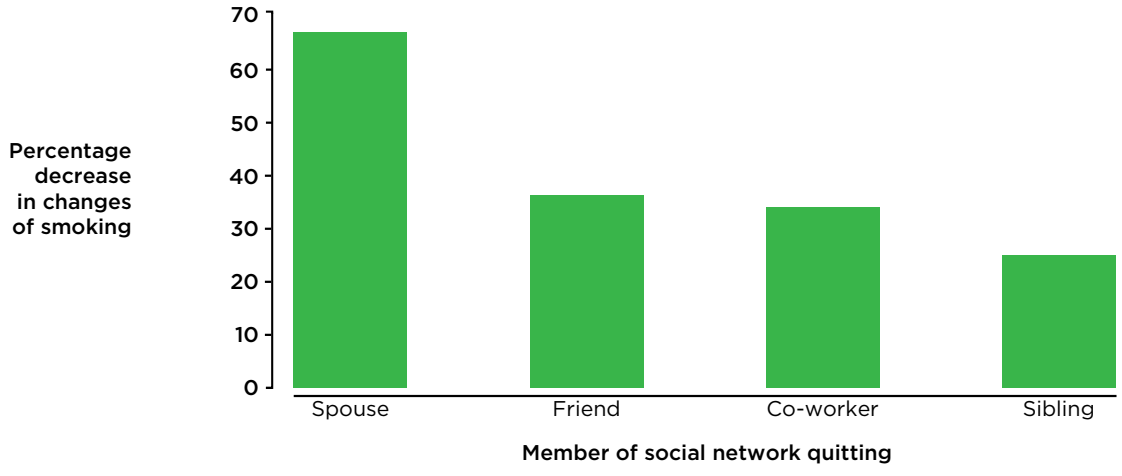
clear that the way we are perceived by others is key to our sense of self and in turn, our health. Research suggests that this powerful social mechanism could be tapped into at minimal cost to encourage people to stick to personal health commitments more closely. When people make declarations of their intention to change their behaviour in the presence of someone else, particularly when that other person is someone they respect or value, it 'raises the stakes' of the commitment. The social pressure people then feel makes it more likely that they will adjust their behaviour to meet the commitment.[31] There is reason to believe that this could work for self-managed health behaviours such as exercising more[32] or quitting smoking.[33]

Another body of research has investigated the way that behaviour can spread contagiously through networks.[34] Social norms are strong influencers of behaviour[35] (**see Box 8 for an example**). Social norms can increase the spread of behaviours for good and ill; contagious behaviours have been recorded for both becoming obese and losing weight, smoking and quitting.[36] A Swedish study of 1.2 million people found that a co-worker committing suicide meant that men were more than three times more likely to kill themselves.[37] Social norm effects have also been documented amongst health professionals and their organisations. Hospitals near to one another tend to have similar practices[38] and GP practices in close proximity to early adopters of promising ideas typically have similar adoption patterns.[39]

BOX 8 • Quitting is contagious

A large, long-term American study[40] has captured health information across more than 12,000 people spanning three generations of families. Physical examinations and questionnaires have been conducted at regular intervals since the study began in 1948. People were asked about whether they smoked and how much at each point as well as several questions about their social connections. The researchers found the following trends in smoking behaviours over 30 years:

- Smokers and non-smokers tend to cluster in social groups.
- Whole clusters of people seem to quit in concert.
- As the overall proportion of smokers has declined over recent decades, so smokers progressively seem to have become socially marginalised.
- Smoking behaviour spreads across both close and distant social ties as the graph below illustrates, with certain social relationships exerting more influence than others.



These strong influences suggest new ways that social networks can enhance the effect of programmes seeking to boost healthy behaviours. Reinforcing desirable social norms can be a low cost, yet effective way of prompting people to automatically adjust their behaviour to mimic peers.[41]

Factor 4: Intrinsic motivation

Being motivated means being moved to do something. It has different aspects: motivation may be intrinsic or extrinsic. Intrinsic motivation is experienced when we find something inherently satisfying. Extrinsic motivation describes the motivation to earn external rewards or avoid punishments.[42]

The concept of intrinsic motivation resonates particularly strongly with the wider debates concerning value spotlighted by the Realising the Value programme.[43] Intrinsic values represent those values that we hold personally dear, for example 'helping people' or 'striving for self-sufficiency'. These values motivate people to volunteer[44] or enable pioneering practitioners to persist in ambitious programmes to restructure their services so that they are more person-centred.[45] Extrinsic motivation tends to be a less sustainable driver of behaviour (depending on the context).[46] This may explain why it can be hard to maintain certain inherently unenjoyable (albeit health enhancing) behaviours such as increasing physical activity, taking medications, or quitting smoking.[47]

Understanding people's intrinsic motivation can help to frame messages aimed at changing behaviour. A study asking people who were predominantly overweight to write about something they most valued in life (e.g. close relationships or music) and then tracked their weight over ten weeks.[48] It found that people who wrote about something they valued, rather than about something that was not valued by them but potentially important to others, exhibited greater weight loss. They hypothesised that focusing on values boosts a sense of self-worth, which in turn makes it easier to control impulses.

A different study experimented with putting up different messages in a hospital reminding clinicians to wash their hands regularly.[49] They found that messages that stressed that hand-washing protects patients from diseases was more effective than messages highlighting that hand-washing protects clinicians themselves from catching diseases. The researchers suggest that prosocial messages can be an effective way of attracting clinicians' attention in busy healthcare environments, especially as this is a group likely to be motivated by helping others.[50] This insight could be applied to the health and social care system more widely. If practitioners can be reconnected to the intrinsic values that often brought them into the sector originally, they can be reoriented towards a person-centred focus using simple, yet salient approaches.

Capturing and profiling patient or service-user stories is not a radical idea for many health and care organisations, but finding effective ways of translating these into tangible action is. Box 9 describes a way that this has been done at the mental health charity Mind. This case study underlines an important behavioural tenet which is that motivation and other cognitive factors do not always need to be present before or in order for a behaviour to take place. The relationship is more circular and self-reinforcing - improvements in skills boost motivation, with increased motivation comes improvements in skills.[51]

BOX 9 • Making person-centredness tangible[52]

Mind, like many organisations, used to have big panels made up of mental health service-users who they would consult on the development of various activities. But the charity found that these groups were not connected enough to the everyday delivery and decision-making of the organisation to be fully influential. Mind changed their approach; instead of large but occasional gatherings of service-users, every individual staff team was given the objective of engaging people in their day-to-day work. Staff were equipped with the skills and resources they needed to do this and were assigned engagement coaches – people with lived experience and expertise in engaging organisations more closely with the populations they serve. The engagement coaches provided them with thinking space and advice to work out how they would make their plans work. Staff were required to report back quarterly on how they were fulfilling their self-set yearly targets. People tended to start small, but over time they adjusted and found they enjoyed and benefitted from this way of working. As a result they got more ambitious in their person-centred processes.

Factor 5: Goal-setting and feedback

Achieving a goal often involves more than deciding what to aim for and then working at it. Breaking goals down into manageable 'chunks' and receiving timely feedback along the way can make it more likely that a person will stay on track and ultimately achieve their goal.

This final section considers the details of goal-setting and draws on theories discussed above in combination. Staying on track to achieve a goal requires motivation. How people respond to the performance feedback they receive along the way is likely to be filtered by their mindset. Setbacks faced by people with a growth mindset are likely to build grit, self-efficacy and skills, particularly when social support is in place to spur them on. In contrast, if someone with a fixed mindset and minimal social ties is striving for a goal which has an extrinsic source, but then faces friction costs or feedback that they are off-course, it is more likely that the will to persevere will wane.

A Health Foundation evidence review has identified that proactive goal-setting can be an effective strategy for promoting self-management activities.[53] Behavioural science has shown that details matter in terms of how people make plans for behaviour change in the pursuit of their goals. There is particularly strong evidence for making plans that incorporate 'implementation intentions'.[54] This involves creating simple 'if-then' plans that gradually build habitual behaviour. It is based on the observation that our behaviour is strongly conditioned by the environment around us: we tend to unconsciously respond to contextual cues. For example seeing fruit at eye level in a fridge makes it more likely we will reach for and eat fruit when we are hungry than when the first thing we see is junk food.[55]

'If-then' plans shift the focus from 'what' to do, to 'how' and 'when' to do it, meaning that people make more 'mindful' plans that anticipate the influence of the world around them. These plans help people with the two hurdles of goal achievement: getting started and staying on track. Forgetting to make a change (especially in demanding situations), picking the right moment to act and avoiding second thoughts based on immediate costs and benefits can all derail people from acting on their best intentions. 'If-then' plans address this by making small actions more salient, actionable and memorable because they are tied to situational cues.

For example, someone who finds it hard to stick to their goal of quitting smoking may find it particularly hard to resist when out with a group of friends who smoke socially. Knowing that the group is bound to end up smoking together part of this person's stop smoking plan could include an implementation intention which says 'if I am going out with friends, then I will pack my e-cigarette'.

Plans like this have been shown to be highly effective in improving goal attainment and habit formation for smoking, as well as for a range of other health-protecting behaviours:[56]

- Physical activity.
- Healthy and unhealthy eating.
- Alcohol consumption.
- Breast self-examination.
- Rehabilitation from injury.
- Vitamin consumption.
- Sun-safety.
- Cancer screening.
- Workplace health and safety.
- Vaccine uptake.
- Contraception use.

Use of precise, actionable implementation intentions in plans is also correlated with better recovery after people relapse on the road to permanent behaviour changes,[57] as does following up intention planning with feedback and proactive 'check-ins' from others to see how sticking to the plan is going. The Health Foundation has previously drawn together many examples of this working in health contexts.[58] The Behavioural Insights Team have also trialled what effect making implementation plans with regular follow-ups can have on helping the unemployed back into work (**Box 10**). Whilst not an example from a health setting, there are parallels between the experience of unemployment and that of chronic ill health[59] and both require significant motivation and effort to overcome associated set-backs.

BOX 10 • Fighting the job search grind with forward-looking plans[60]

JobCentres historically used meetings with job hunters to go over the past week's activities and collect evidence that a job search was underway. A new approach sees JobCentre advisors and job seekers working together to identify specific job search activities linked to their daily routines that they could commit to completing in the coming week. This had a number of positive effects during a pilot run by The Behavioural Insights Team. The rate of job seekers moving into jobs rose by 5 percentage points, which is a substantial effect size in this policy area. Significant positive effects have been maintained as the study was scaled up from pilot phase to full nationwide roll-out. In addition, staff at the participating pilot Job Centre have reported greater staff satisfaction and wellbeing, most notably perhaps because almost two-thirds now say that what they do is worthwhile (previously only 45 per cent said this).

This evidence of simple changes to standardised processes is promising for health. Implementation planning could make discharge and care planning more person-centred, by ensuring that self-care advice is moulded to a person's daily routine or habits. As a result, we predict that the efficacy of planning processes would rise.

Conclusion

This report provides health and care audiences with a framework for understanding the drivers of behaviour, plus five factors that show how different behavioural mechanisms interact and play out. These factors seek to provide approaches that can help those grappling with how to encourage behaviour change for health to happen. These approaches can be hard-wired into the design of services, programmes, community initiatives, and indeed to the very lives of the people who engage with them.

The examples and case studies in this report illustrate the application of these theories and there is much to suggest that there can be more promising applications in future. Trialling, learning from results and adapting programmes of work accordingly will be key for future applications of these theories.[61] The Realising the Value programme Action Focused Guides (due for release in 2016) will explain how to design factors that make health-promoting behaviours more likely into person- and community-centred activities for health in wellbeing.

Endnotes

1. The first requirement - identifying the relevant behaviours - will be addressed through working with Realising the Value local partner sites. BIT's Action Focused Guides will focus on the third requirement (ways of facilitating these behaviours).
2. Michie, S., van Stralen, M. M., and West, R. (2011) The behaviour change wheel: a new method for characterising and designing behaviour change interventions. 'Implementation Science.' 6(1), 42.
3. Dweck, C. S. (2006) 'Mindset.' New York NY: Random House; Yeager, D. S., Johnson, R., Spitzer, B. J., Trzesniewski, K. H., Powers, J., and Dweck, C. S. (2014) The far-reaching effects of believing people can change: Implicit theories of personality shape stress, health, and achievement during adolescence. 'Journal of personality and social psychology.' 106(6), 867.
4. Yeager, D. S., and Dweck, C. S. (2012) Mindsets that promote resilience: When students believe that personal characteristics can be developed. 'Educational Psychologist.' 47(4), 302-314.
5. House of Commons Health Committee (2014) 'Managing the care of people with long–term conditions.' Second Report of Session 2014–15. London: House of Commons. See: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/401/401.pdf
6. Marks, R., and Allegrante, J. P. (2005) A review and synthesis of research evidence for self-efficacy-enhancing interventions for reducing chronic disability: implications for health education practice (part II). 'Health promotion practice.' 6(2), 148-156.
7. Heslin, P. A., Vandewalle, D. and Latham, G. P. (2006) Keen To Help? Managers' Implicit Person Theories and their Subsequent Employee Coaching. 'Personnel Psychology.' 59(4), 871-902.
8. Laws, R. A., Kemp, L. A., Harris, M. F., Davies, G. P., Williams, A. M., and Eames-Brown, R. (2009) An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary healthcare: a grounded theory study. 'Implementation Science.' 4(1), 66.
9. Ibid; Williams, S. J., and Calnan, M. (1994) Perspectives on prevention: the views of general practitioners. 'Sociology of Health & Illness.' 16(3), 372-393.
10. Heslin, P. A., Vandewalle, D., and Latham, G. P. (2006) KEEN TO HELP? MANAGERS' IMPLICIT PERSON THEORIES AND THEIR SUBSEQUENT EMPLOYEE COACHING. 'Personnel Psychology.' 59(4), 871-902
11. Yeager, D. S., Paunesku, D., Walton, G. M., and Dweck, C. S. (2013) 'How can we instill productive mindsets at scale? A review of the evidence and an initial R&D agenda.' A White House White Paper prepared for the meeting on 'Excellence in Education: The Importance of Academic Mindsets.' Paunesku, D., Yeager, D., Romero, C., and Walton, G. (2012) 'A brief growth mindset intervention improves academic outcomes of community college students enrolled in developmental mathematics courses.' Unpublished manuscript. Stanford CA: Stanford University.
12. Bandura, A. (1977) Self-efficacy: toward a unifying theory of behavioral change. 'Psychological review.' 84(2), 191.
13. Duckworth, A. L., Peterson, C., Matthews, M. D., and Kelly, D. R. (2007) Grit: perseverance and passion for long-term goals. 'Journal of personality and social psychology.' 92(6), 1087.; Shechtman, N., DeBarger, A.H., Dornsife, C., Rosier, S., and Yarnall, L. (2013) 'Promoting grit, tenacity, and perseverance: Critical factors for success in the 21st century.' Washington DC: U.S. Department of Education Office of Educational Technology.
14. Marks, R., and Allegrante, J. P. (2005) A review and synthesis of research evidence for self-efficacy-enhancing interventions for reducing chronic disability: implications for health education practice (part II). 'Health promotion practice.' 6(2), 148-156.
15. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf
16. Marks, R., and Allegrante, J. P. (2005) A review and synthesis of research evidence for self-efficacy-enhancing interventions for reducing chronic disability: implications for health education practice (part II). 'Health promotion practice.' 6(2), 148-156.
17. Kitzman, H., Olds, D. L., Henderson, C. R., Hanks, C., Cole, R., Tatelbaum, R. and Barnard, K. (1997) Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: a randomized controlled trial. 'Jama.' 278(8), 644-652.
18. http://fnp.nhs.uk/evidence/what-do-young-mums-think; http://www.nice.org.uk/guidance/ph40/documents/social-and-emotional-wellbeing-early-years-expert-report-42
19. Burnette, J. L., and Finkel, E. J. (2012) Buffering against weight gain following dieting setbacks: An implicit theory intervention. 'Journal of Experimental Social Psychology.' 48(3), 721-725.
20. The Behavioural Insights Team 'EAST: Four simple ways to apply behavioural insights.' http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf
21. Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. and Geddes, I. (2010) 'Fair society, healthy lives: strategic review of health inequalities in England post 2010.' The Marmot Review.
22. Bettinger, E. P., Long, B. T., Oreopoulos, P. and Sanbonmatsu, L. (2009) 'The role of simplification and information in college decisions: Results from the H&R Block FAFSA experiment (No. w15361).' Cambridge MA: National Bureau of Economic Research.
23. With thanks to Dr Karen Eastman, Clinical Director at Horsham & Mid Sussex CCG for supplying this case study.
24. With thanks to Lisa Swainston, Stronger Communities Wellbeing Manager at Doncaster Metropolitan Borough Council for supplying this case study.

25. Putnam, R. D. (2001) 'Bowling alone: The collapse and revival of American community.' New York NY: Simon and Schuster.
26. Aked, J., Marks, N., Cordon, C. and Thompson, S. (2009) 'Five Ways to Wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's well-being.' London: Nef.
27. Griffin, J. (2010) 'The lonely society?. Mental Health Foundation.'; Cacioppo, J. T. and Patrick, W. (2008) 'Loneliness: Human nature and the need for social connection.' London: WW Norton & Company; Cacioppo, J. T., Fowler, J. H. and Christakis, N. A. (2009) Alone in the crowd: the structure and spread of loneliness in a large social network. 'Journal of personality and social psychology.' 97(6), 977.
28. Charmaz, K. (1983) Loss of self: a fundamental form of suffering in the chronically ill. 'Sociology of health & illness.' 5(2), 168-195.
29. Antonucci, T., Fuhrer, R., and Jackson, J. (1990) Social support and reciprocity: A cross-ethnic and cross-national perspective.; Rintala, D. H., Young, M. E., Hart, K. A. and Fuhrer, M. J. (1994) The relationship between the extent of reciprocity with social supporters and measures of depressive symptomatology, impairment, disability, and handicap in persons with spinal cord injury. 'Rehabilitation Psychology.' 39(1), 15.
30. Schwartz, C. E. and Sendor, R. M. (1999) Helping others helps oneself: response shift effects in peer support. 'Social Science & Medicine.' 48(11), 1563-1575.; Brown, S. L., Nesse, R. M., Vinokur, A. D. and Smith, D. M. (2003) Providing social support may be more beneficial than receiving it results from a prospective study of mortality. 'Psychological Science.' 14(4), 320-327.
31. The Behavioural Insighs Team 'EAST: Four Simple Ways to Apply Behavioural Insights' http://www.behaviouralinsights.co.uk/publications/east-four-simple-ways-to-apply-behavioural-insights/
32. Williams, B. R., Bezner, J., Chesbro, S. B. and Leavitt, R. (2005) The effect of a behavioral contract on adherence to a walking program in postmenopausal African American women. 'Topics in Geriatric Rehabilitation.' 21(4), 332-342.
33. Giné, X., Karlan, D. and Zinman, J. (2010) Put your money where your butt is: a commitment contract for smoking cessation. 'American Economic Journal: Applied Economics.' 213-235.
34. Christakis, N. A. and Fowler, J. H. (2010) Connected: the amazing power of social networks and how they shape our lives. London: HarperPress.
35. Cialdini, R. B. (1987) 'Influence: The Psychology of Persuasion.' Harper Business.
36. Christakis, N. A. and Fowler, J. H. (2008) The collective dynamics of smoking in a large social network. 'New England Journal of Medicine.' 358(21), 2249-2258.
37. Interestingly, the effect was not present for women. Hedström, P., Liu, K-Y. and Nordvik, M.K. (2008) Interaction domains and suicide: a population-based panel study of suicides in Stockholm, 1991–1999.' Social forces.' 87.2, 713-740. Cited in Christakis and Fowler (2009), 128.
38. Angst, C. M. and Agarwal, R. (2007) Keeping up with the Jones': Influence from peer hospitals on EMR diffusion. 'Center for Health Information and Decision Systems.' Vol.2, Issue 2A.
39. Stokes, K., Barker, R. and Pigott, R. (2014) 'Which doctors take up promising ideas? New Insights from open data.' London: Nesta.
40. Christakis, N. A. and Fowler, J.H. (2008) The collective dynamics of smoking in a large social network. 'New England Journal of Medicine.' 358.21 (2008): 2249-2258.
41. Institute for Government, MINDSPACE, http://www.instituteforgovernment.org.uk/sites/default/files/publications/MINDSPACE.pdf
42. Ryan, R. M. and Deci, E. L. (2000) Intrinsic and extrinsic motivations: Classic definitions and new directions. 'Contemporary educational psychology.'25(1), 54-67.
43. http://www.nesta.org.uk/sites/default/files/how_should_we_think_about_value_in_health_and_care.pdf
44. Wilson, J. (2000) Volunteering. 'Annual Review of Sociology.' 215-240.
45. This was a strong theme amongst commissioners and practitioners interviewed as part of preparations for this paper.
46. Ryan, R. M., Patrick, H., Deci, E. L. and Williams, G. C. (2008) Facilitating health behaviour change and its maintenance: Interventions based on self-determination theory. 'European Health Psychologist.' 10(1), 2-5.
47. Ibid: see Ryan et al., (2008) for an overview of RCTs in this area; Williams, G. C., McGregor, H. A., Sharp, D., Levesque, C., Kouides, R. W., Ryan, R. M. and Deci, E. L. (2006) Testing a self-determination theory intervention for motivating tobacco cessation: supporting autonomy and competence in a clinical trial. 'Health Psychology.' 25(1), 91.
48. Logel, C. and Cohen, G. L. (2012) The role of the self in physical health testing the effect of a values-affirmation intervention on weight loss. 'Psychological Science.' 23(1), 53-55.
49. Grant, A. M. and Hofmann, D. A. (2011) It's Not All About Me Motivating Hand Hygiene Among Health Care Professionals by Focusing on Patients. 'Psychological Science.' 22(12), 1494-1499.
50. A similar conclusion was made in another study linking public service employees remote from the frontline with the pro-social impacts of their work: Grant, A. M. (2008) Employees without a cause: The motivational effects of prosocial impact in public service. 'International Public Management Journal.' 11(1), 48-66.
51. Cox, K. E. and J. T. Guthrie (2001) Motivational and Cognitive Contributions to Students' Amount of Reading. 'Contemporary Educational Psychology.' 26(1): 116-131.; Carpentieri, J.D. (2012) 'Family learning: a review of the research literature: A report prepared for NIACE by the National Research and Development Centre for adult literacy and numeracy.' London: Institute of Education, University of London
52. With thanks to Brigid Morris, Head of Leadership and Engagement at Mind for supplying this case study.
53. The Health Foundation (2011) 'Helping People Help Themselves.' See: http://www.health.org.uk/sites/default/files/HelpingPeopleHelpThemselves.pdf

54. Gollwitzer and Sheeran, see: http://cancercontrol.cancer.gov/brp/constructs/implementation_intentions/goal_intent_attain.pdf
55. Wansink, B. (2006) 'Mindless Eating – Why We Eat More Than We Think.' New York: Bantam-Dell.
56. Hagger, M. S. and Luszczynska, A. (2014) Implementation intention and action planning interventions in health contexts: State of the research and proposals for the way forward. 'Applied Psychology: Health and Well-Being.' 6(1), 1-47.
57. Gollwitzer, P. M. and Sheeran, P. (2006) Implementation intentions and goal achievement: A metaanalysis of effects and processes. 'Advances in Experimental Social Psychology.' 38, 69-119.
58. The Health Foundation (2011) 'Helping People Help Themselves.' See: http://www.health.org.uk/sites/default/files/HelpingPeopleHelpThemselves.pdf
59. Linn, M. W., Sandifer, R. and Stein, S. (1985) Effects of unemployment on mental and physical health. 'American Journal of Public Health.' 75(5), 502-506.
60. The Behavioural Insights Team Update report 2013-2015, see: http://www.behaviouralinsights.co.uk/publications/the-behavioural-insights-team-update-report-2013-2015/
61. The Behavioural Insights Team (2012) 'Test, Learn, Adapt.' See: https://www.gov.uk/government/publications/test-learn-adapt-developing-public-policy-with-randomised-controlled-trials

About Realising the Value

Realising the Value is a programme funded by NHS England to support the NHS Five Year Forward View. The programme seeks to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets.

There are many good examples of how the health and care system is already doing this. For example, recognising the importance of people supporting their peers to stay as well as possible or coaching to help people set the health-related goals that are important to them.

Realising the Value is not about inventing new approaches, it's about strengthening the case for change, identifying evidence-based approaches that engage people in their own health and care, and developing tools to support implementation across the NHS and local communities. But putting people and communities genuinely in control of their health and care also requires a wider shift. The programme is therefore considering the behavioural, cultural and systemic change needed to achieve meaningful transformation.

www.realisingthevalue.org.uk.

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