Realising the Value

Empowering people, engaging communities

Spreading change

A guide to enabling the spread of person- and community-centred approaches for health and wellbeing

Guide

September 2016

Realising the Value
Empowering people, engaging communities

About this guide

This guide outlines how behavioural science can help spread the take-up of person- and community-centred approaches to health and wellbeing.

It is aimed at people who champion these approaches in health and social care, in other statutory bodies and in community-based organisations.

The guide was written by **Hannah Burd** and **Michael Hallsworth**, The Behavioural Insights Team, as part of the work of the Realising the Value programme.

We hope you find it useful.

Acknowledgements

Many thanks to those who have provided input and advice to this guide: members of the Realising the Value consortium, local partner sites and their wider stakeholders, advisory group members and staff at The Behavioural Insights Team. Thanks to the following who gave expert interviews, the opportunity to observe practice or detailed feedback which informed the guide:

Positively UK and members of their peer-support networks

Big Life Group, Being Well Salford and their participants

Creative Minds and people who participate in their groups

Penny Brohn UK and their clients

Unlimited Potential (with Inspiring Communities Together), plus fathers involved with the Salford Dadz project and older people involved in Salford Together programmes

The local commissioners and wider communities of interest related to each of the above partner sites

Commissioning for Person-Centred Care Working Group, NHS England

Dr Katie Coleman

Dr Phil Cumberlidge

Dr Dimple Vyas

Dr Karen Eastman

Impact Health Coaching

Elizabeth Carter, Mid Sussex District Council

Lisa Swainston, Doncaster Metropolitan Borough Council

Tim Straughan, Leeds CCGs

Dr Steve Laitner

Hilda Yarker, NHS North West Commissioning Support Unit

Alex Whinnom, GMCVO

Brigid Morris, Mind

Sian Summers, NHSE

Debbie Cargill, NHSE

Vinice Thomas, NHSE

Hazel Fisher, NHSE

Anna McEwan, Shared Lives

Spreading change

A guide to enabling the spread of person- and community-centred approaches for health and wellbeing

Introduction

What switched me on to more person- and community-centred approaches? Seventeen years as a GP. When you follow the medical line alone, you lose people. For example, after many years of talking with people about losing weight I found that if you ask different questions you get different answers - money or housing problems or how they're feeling in themselves may be at the root of it. Unless you help with that you'll find it hard to move forward together. People with a long-term condition really need this. It's unsurprising, for instance, that someone recently diagnosed with diabetes might put their head in the sand - because it's overwhelming to make big lifestyle changes. People need to have different, much more holistic conversations about what matters to them, not what we think matters for them.

Dr Karen Eastman, Clinical Director, Horsham and Mid Sussex CCG

A real motivator is when people tell you that the services they are receiving are not good enough for them – somehow we need to find a way to tap into the intrinsic motivation of professionals to want to do better for patients. Key to this will be joining up the enthusiasts - the champions - so they can form a critical mass and start to make change happen.

Dr Katie Coleman, Chair of Commissioning for Person-Centred Care Working Group, NHS England

Making these changes has little to do with budgets and more to do with culture and behaviour change. In fact, today's lack of funding is forcing different thinking and more openness to try something new. The places that are making progress are those with strong leadership and the will to try something different.

Alex Whinnom, Chief Executive, Greater Manchester Centre for Voluntary Organisation

We've become more flexible in the way we work with people. We have grown in confidence as we've gone along - the positive feedback coming from communities reinforces this. Before this, we were finding that a one-size-fits-all approach was getting us and the people we were trying to help nowhere. Professional fear was a big barrier at first, but support to try new things throughout our organisation helped us overcome and become more comfortable with the uncertainty that can accompany change.

Lisa Swainston, Stronger Communities Wellbeing Manager, Doncaster Metropolitan Borough Council

The benefits of thinking about behaviour and person- and community-centred approaches

People's behaviour strongly influences their health.[1] However, even when people know what the 'healthy' thing to do is, and intend to do it, they often encounter significant barriers. Awareness and intention are rarely enough; we need to find other ways of helping people change their behaviour. The challenge for practitioners is to identify the most effective ways of supporting people to make these changes, and ensuring that they become sustainable.

The potential gains from helping people manage their own health using person- and community-centred approaches are great. These approaches represent a source of untapped value for the health system.[2] If developed effectively, systematic evidence reviews of self-management programmes suggest they can result in raised self-confidence, better quality of life, improved clinical outcomes, and greater achievement of goals that are important to the person.[3]

Helping people to help themselves could also result in more meaningful interactions between people with long-term health conditions and their practitioners. Where practitioners have the sense that they are sustainably supporting people to live life in a fulfilling way, they are likely to experience increased job satisfaction.[4]

The challenge of spreading new approaches

The evidence for the benefits of promoting a person- and community-centred approach in health and wellbeing settings is strengthening.[5] Yet spreading improvement and change within health and social care organisations is notoriously challenging.[6] Behavioural science offers some reasons for why this is the case:

- People tend to be confronted with much more information than they are willing or able to process.[7]
- People seek to minimise effort and are disproportionately affected by small barriers to change.[8]
- People typically stick with the way things are - the status quo.[9]
- People tend to interpret facts using mental 'shortcuts' (rules of thumb or assumptions) that confirm our existing views.[10]

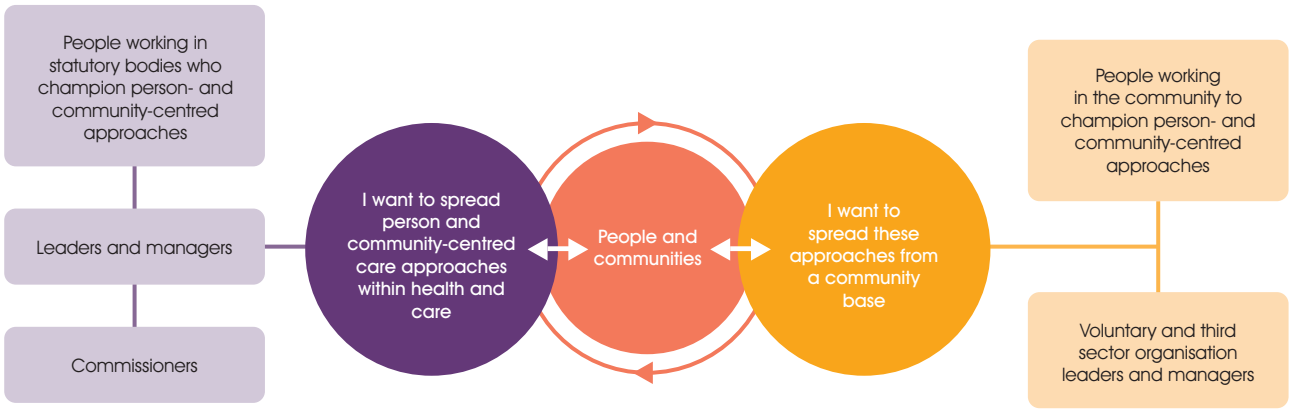
These factors mean that efforts which try to affect behaviour change primarily by sharing ever more information are likely to flounder.[11]

Who is this guide for?

This guide is for people who champion these approaches in health and social care, in other statutory bodies and in community-based organisations. Change is more likely to spread when both statutory organisations and community-based organisations align approaches.[12] For this reason we feature case studies from both parts of the system. They are colour coded to enable different audiences to navigate the guide easily.

Diagram 1 illustrates the different uses of this guide. It clarifies the different aims of behaviour change that readers may want to achieve:

Diagram 1: **What is your aim?**



We have prepared a separate guide *Supporting self-management* for practitioners in either sector working to provide person- and community-centred approaches who would like to increase their impact on self-management behaviours.

How this guide helps

This guide is part of the NHS England-funded Realising the Value programme led by Nesta and the Health Foundation, which seeks to develop person- and community-centred approaches for health and wellbeing. The programme is doing so by building the evidence base and developing tools, resources and networks to support the spread and impact of these approaches.

This guide offers two things: a framework for understanding and changing behaviour, and real-world examples of how these changes happen in practice, coded by the audiences in Diagram 1.

1. A framework for understanding and changing behaviour

The UK's Behavioural Insights Team (BIT) has worked with public sector policymakers and practitioners over the last five years to develop the EAST framework, which is an accessible way of applying behavioural science to real-world issues. The core message of EAST is that if you want to encourage a behaviour, you should make it Easy, Attractive, Social and Timely.[13]

- **Make it Easy**: Small, seemingly irrelevant, details that make a task more challenging or effortful can make the difference between doing something and putting it off – sometimes indefinitely.
- **Make it Attractive**: Attracting attention and incentivising behaviour are important for prompting people to behave in a new way and maintain behaviour change.
- **Make it Social**: People are social creatures; we are influenced by what those around us do and say, often more than we are consciously aware of.
- **Make it Timely**: The same offer or 'prompt' to change behaviour made at different times can have different effects.

This guide uses the EAST framework to organise ideas and examples. The four principles in the framework are underpinned by a body of evidence from behavioural science.[14] However, the EAST framework does not attempt to capture all the nuances of this research. It is intended to be a user-friendly and memorable tool for considering the main drivers of behaviour and generating effective approaches for addressing them.

The Realising the Value programme has published an accompanying report that looks at the theories relevant to the ideas outlined in this guide in more depth: *Making the change: Behavioural factors in person- and community-centred approaches to health and wellbeing*.[15] Readers may find that report useful to read alongside this action-focused guide.

2. Real-world examples of changing behaviours to spread person- and community-centred approaches

This guide provides examples from the five Realising the Value partner sites, categorised by the EAST framework. Each partner site exemplifies a person- and community-centred approach for health and wellbeing. The sites and their evidence-based approaches[16] are:

- **Positively UK: Peer support** for people living with HIV
  Peer support takes place when people with similar long-term conditions or health experiences support each other in order to better understand the condition and aid recovery or self-management.
- **Big Life Group** with **Being Well Salford: Health coaching** for a range of health behaviours
  Health coaching helps people to set goals and take actions to improve their health or lifestyle.
- **Penny Brohn UK: Self-management education** for people living with and recovering from cancer
  Self-management education includes any form of formal education or training for people with long-term conditions which focuses on helping people to develop the knowledge, skills and confidence to effectively manage their own health and care.
- **Creative Minds: Group activities** to promote health and wellbeing for people living with mental health conditions
  There is a wide range of group activities that can be beneficial to support health and wellbeing. These range from exercise classes, to cookery clubs, community choirs, walking groups and gardening projects.
- **Unlimited Potential** with **Inspiring Communities Together: Asset-based approaches** in a health and wellbeing context
  The aim of asset-based practice is to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health.

The guide features a number of low-tech, pragmatic and manageable activities which can increase the spread of person- and community-centred health and wellbeing programmes.

We have taken effective approaches from both academic theory and the five sites and boiled them down to the mechanisms that seem to work most effectively. These are featured in coloured boxes throughout the guide (summarised and hyperlinked in Diagrams 2-3). Practitioners can then incorporate these elements into the design of their own health and wellbeing programmes.

Diagram 2: Spreading person- and community-approaches in health and care

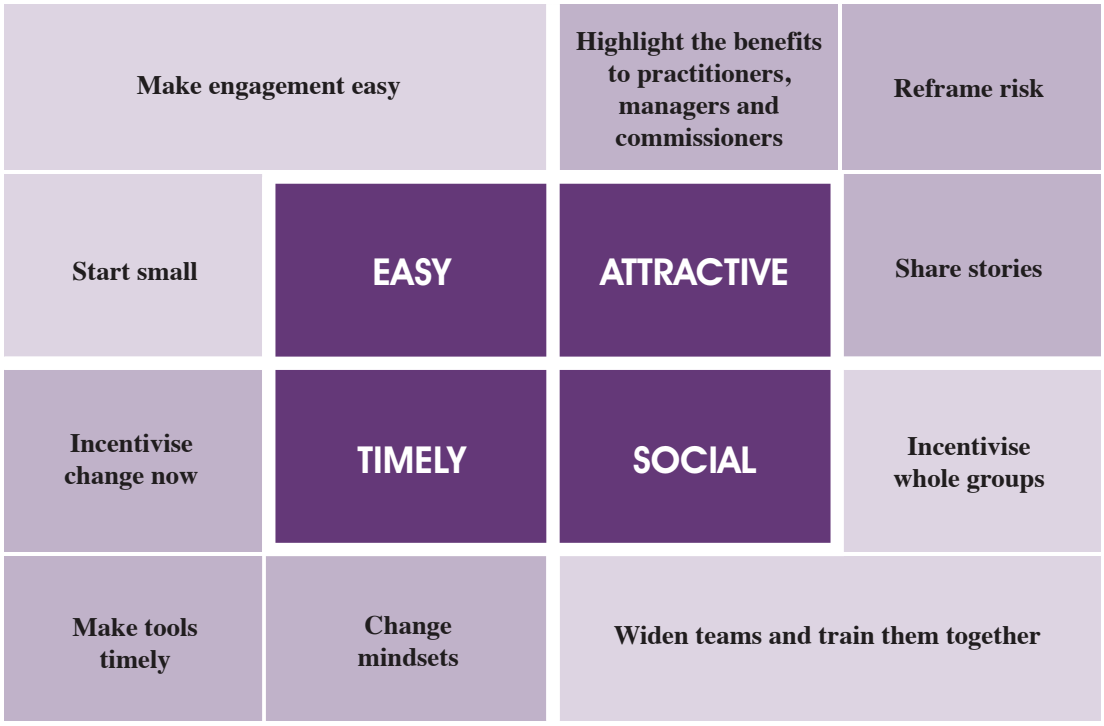
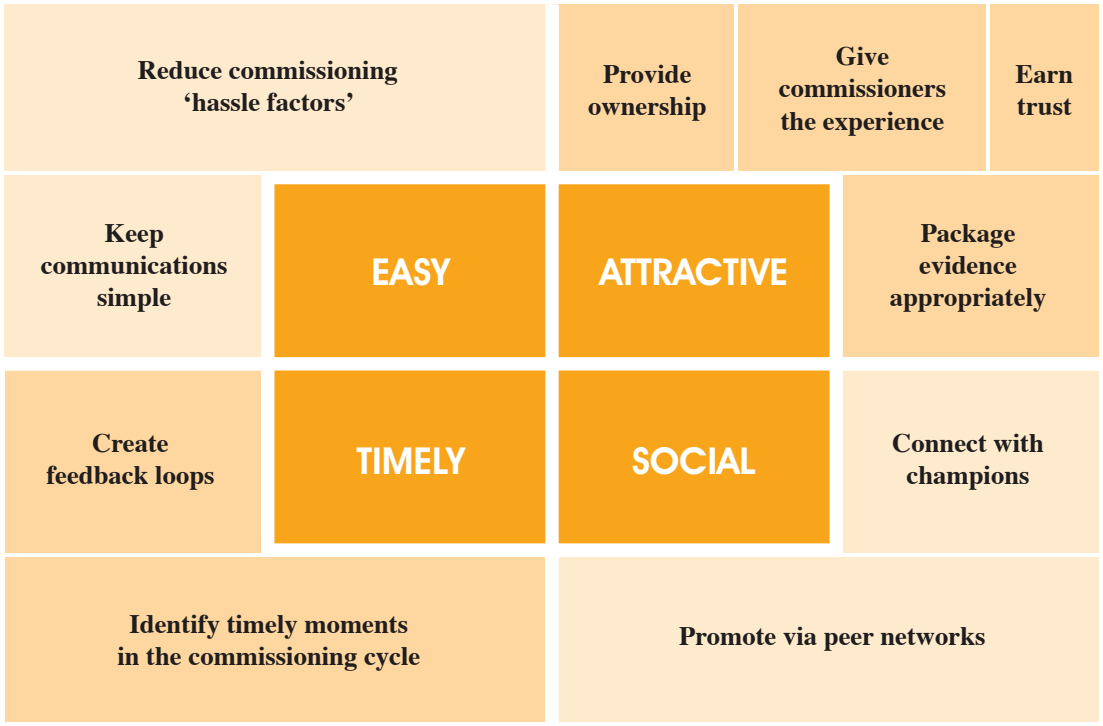


Diagram 3: Spreading person- and community-approaches from a community base



What this guide does not address

This guide is focused on the enablers and barriers to behaviour change in the context of spreading person- and community-centred approaches. It does not address more systemic barriers to change such as budget constraints, divergent mandates or misaligned priorities.

The guide deliberately avoids an over-prescriptive explanation of how to implement the recommended approaches. Whilst case studies from the five partner sites are used to illustrate the application of the theory, this is not a 'how to' guide. Each local area is unique and allowing new areas to take ownership of the implementation of effective techniques is likely to increase the uptake and spread of successful approaches.[17] The guide also does not detail how to set up pilots or evaluate services. The incremental approach to doing so advocated by the Behavioural Insights Team is described in existing publications.[18]

A common critique of approaches derived from behavioural science is that they focus on individuals rather than systemic, structural or cultural factors.[19] We acknowledge that the challenges facing people in realising better health and wellbeing outcomes for themselves or their local communities can be structural and ingrained - spanning inequalities of housing, employment, education, language, accessibility, (dis) ability and poverty, necessitating a whole-system response.[20] The approaches outlined in this document will not address the whole problem.

The wider Realising the Value programme[21] is working to address some of these more structural challenges. It provides a narrative and consolidation of the evidence for person- and community-centred approaches,[22] as well as a set of recommendations relating to systems enablers and barriers. Access the programme resources via www.realisingthevalue.org.uk.

Research approach and limitations

The guide's research approach is outlined in an annex at the end. The ideas and examples listed in this guide are underpinned by evidence. However, many of the studies in this area have taken place at a relatively small scale and require wider testing and replication before their reliability is known. It is recognised that context matters for the successful implementation of any intervention: what works in one area may not work to the same extent in another where the mix of local assets, stakeholders or providers may be different.[23] Therefore, we view the evidence in this publication as promising and indicative rather than conclusive.

A note about language

Wherever possible we have sought to use the word 'people' rather than 'service users' or 'patients'. At times the latter terms are used for clarity when describing people in relation to those who work supportively alongside them as practitioners, providers or commissioners in a health and wellbeing context. We wish to avoid language which suggests relationships of imbalance or dependency. We seek instead to consider people holistically; taking account of their capabilities, motivation, relationships and personal or community assets.

Spreading person- and community-centred approaches by making it **EASY**

Giving attention to the small, practical barriers that get in the way of the adoption of new behaviours can have a surprisingly large impact - more so than efforts to change people's dispositions towards those approaches.[24]

This section features four examples:

Health and care providers and commissioners	Community-based organisations
Make engagement easy	**Reduce commissioning 'hassle factors'**
Start small	**Keep communications simple**

Health and care organisations

Make engagement easy

Something that gets in the way of practitioners connecting people with community-based support is a lack of awareness of the range of community assets (services, facilities, initiatives, capabilities and networks) available. Locations, times and activities may change more rapidly than practitioners are able to keep up with. Mechanisms which make signposting to reliable community-based organisations as easy as possible are likely to increase the uptake of their services within health and care organisations.

Social prescribing is frequently recommended as a way of connecting people with 'more than medicine' approaches to healthcare.[25] It is important to design social prescribing processes which are easy for practitioners to use, and which dovetail easily with existing practice.[26]

One example of this is the social prescription pads used by GPs who work with **Being Well Salford**.[27] These reduce the hassle factor for the GP and people seeking a 'more than medicine' approach by establishing an easy to use and trusted link to the local social prescribing service. GPs can write paper 'prescriptions' for people that are then collected regularly from the GP practice by the community-based organisation (Social Adventures). The organisation then gets in touch with the person directly to discuss the support they seek. People can then be linked up with a health coach and any other appropriate and convenient community-based activities.

This way, referrers do not need to stay up-to-date on the range or contacts of community groups and people can access the quality-assured support that is right for them in a timely way. Nor do referrers need to log-in to separate systems or adopt new routines. Filling out a paper referral is a familiar behaviour to GPs and patients alike.

This approach is compatible with digital and paper-free systems too. A similar scheme is operated by **Mid Sussex District Council's Health and Wellbeing Team**. It is linked electronically to GP computer systems so that they can pre-populate forms with patient details and submit secure applications easily. Other studies have found that removing small barriers to access, for example by pre-populating administrative sections of forms, can significantly boost the rates of people completing and submitting those forms and receiving subsequent assistance.[28]

Start small

Starting small makes it easier to encourage people away from the status quo.[29] Asking people to try a small project first can build confidence in an approach and break down uncertainty.[30] It can also turn seemingly insurmountable tasks into manageable 'chunks' that can be undertaken incrementally.[31]

This can take effect in a number of ways: small projects which involve learning and adaptation can increase understanding of a given rationale and demonstrate proof of concept. But they can also function like a 'foot in the door', where people seek to be consistent with their previous actions.[32]

Positively UK's commissioners and clinicians in East London moved from relatively low levels of integration with peer-support workers to requesting that they become a daily presence following positive experiences of a small scale outreach project. At first, a peer-support worker attended an HIV clinic for half a day once a week to provide a link for patients between their care in hospital and support in the community. The clinical team within the hospital could see the value of this and have now resourced a peer-support worker role, present across all the clinics they provide, as part of the multidisciplinary team working with patients.

Community-based organisations

Reduce commissioning 'hassle factors'

Commissioners in each of the Realising the Value partner sites described heavy workloads and challenging targets to meet. They regularly experience a sense of 'cognitive overload', whereby it becomes increasingly difficult to engage with new calls on their attention.[33]

In recognition of this, partner sites now make it easy to commission a complete service package which lightens their commissioners' load. For example, **Being Well Salford** manages a number of sub-contracts in the delivery of their health coaching services. Packaging these services together reduces contracting burden and complexity for commissioners without compromising outcomes. Being Well Salford is now trusted to coordinate onward referrals to more than medicine support services (e.g. weight management and exercise referral schemes) at scale community-wide.

Their commissioners benefit from Being Well Salford's position: it is an organisation which has an overview and contacts with an array of local community assets. Nonetheless, it remains closely in touch with the local community - through the health coaching service it provides as well as the employment of local people as coaches - which enables it to provide a service that meets the community's needs.

Positively UK and **Unlimited Potential** make it easy for their commissioners to make sense of what they offer by clearly signalling their awareness of and close alignment with their commissioners' priorities. They ensure that any discussions or tender applications 'speak the language' of their commissioners - using the same terminology and foregrounding the same priorities.

Keep communications simple

Whether in bid documents, business cases, presentations or chance meetings, community-centred organisations are likely to experience more success in engaging commissioners when they clearly articulate what they do and the evidence to support it, using short, simple, salient descriptions.[34]

Too much information can quickly lead to a kind of 'cognitive tax' where it becomes much harder to make a clear decision.[35] A consistent finding across many Behavioural Insights Team trials is that longer communications - however carefully crafted - have less impact than shorter, simpler ones.[36]

Spreading person- and community-centred approaches by making it ATTRACTIVE

Making something attractive involves two main things: drawing attention to it, and making the action more appealing. These goals can be treated separately, but in combination, they can reinforce each other.

This section features a number of examples:

Health and care providers and commissioners	Community-based organisations
Reframe risk	**Provide ownership**
Highlight the benefits to practitioners, managers and commissioners	**Give commissioners the experience**
	Earn trust
Share stories	**Package evidence appropriately**

Health and care organisations

Reframe risk

Countering risk aversion is a challenge when trying to spread innovation.[37] Risks (whether real or perceived) could include financial, clinical or reputational risks and will depend on the setting - frontline health or care practitioners may be concerned with different risks compared to financiers.[38]

People are generally risk averse - we prefer certainty to a gamble.[39] Moreover, the decision to take a risk (in this case adopting a new way of working; incorporating person- and community-centred approaches) is likely to depend on how that step is framed in terms of gains and losses.[40] Some ways to do so are:

- Foregrounding the potential benefits of change, and avoiding overemphasising immediate costs or potential losses. Whilst over-optimism should be avoided, it should also be recognised that taking a narrow focus on the risks of any given innovative project (especially in the public sector where positive impacts may be hard to quantify and the stakes are high) is likely to stifle its adoption.[41]
- Holding inclusive discussions about risk mitigation which explicitly frame risk as something to be managed rather than avoided entirely.[42] For example, in order to mitigate the risk to any one organisation, **Being Well Salford's** health coaches are employed across several local social enterprises. The respective employers receive a reassuring signal that they do not have to take on the risk of too many new hires. The coaches are trained and managed to the same high standards and provide consistently high quality support to their community.

- Research suggests that leaders have a key role to play in underwriting risks, of emphasising the risks of not acting and promoting a culture of risk mitigation rather than risk avoidance.[43] Thus possible benefits should be factored into risk registers, as should risk mitigation plans.

Highlight the benefits to practitioners, managers and commissioners

Typically arguments for person- and community-centred care approaches foreground the benefits for people who use health services in the first instance. Whist this is not wrong, it belies the fact that taking a person- and community-centred approach is often experienced as 'win-win' for practitioners and the people they work with alike. **Unlimited Potential** has experienced greater success in terms of attracting practitioner attention when framing the change in terms of the benefits that will be experienced by busy practitioners in the first instance.[44]

Health and care workers frequently act on the basis of intrinsic motivation - that is, a drive to help others.[45] This is in contrast to extrinsic motivation - a drive for personal gain or recognition, or the avoidance of punishment. However, the systems in which they work can be geared against intrinsic motivation at times. For example, a drive to meet targets in order to avoid penalties, rather than to meet person-centred objectives, may start to tap into extrinsic rather than intrinsic motivation.[46]

A way of re-engaging professionals in person- and community-centred approaches can be to attract attention towards the ways that doing so can meet their immediate needs in addition to those of the people they serve.[47] For example:

- Frame the move to a person-centred approach as introducing a more sustainable relationship between practitioners and patients, one which is more balanced between both parties.[48]
- If practitioners fear or experience an initial increase in workload from a move towards shared decision-making, this should be presented as temporary.[49]
- Find timely ways of feeding back data on reductions in service demand as a result of moves to person- and community-centred approaches.[50] This can reinforce a sense of making progress towards prevention, and a sustainable workload, rather than forever 'firefighting' acute crises.[51]
- Get the input of community-centred organisations early. Commissioners of **Being Well Salford** and **Unlimited Potential** find that if they work with these organisations from the stage of writing service specifications, they ultimately establish contracts which are more likely to achieve outcomes.[52]
- Work with community-based organisations to consult marginalised or disadvantaged groups: community-based organisations are uniquely placed to support commissioners to fulfil their obligations to consult meaningfully with the local community. This point is elaborated further in the 'Share stories' box below.

Share stories

Stories and anecdotes alone are rarely sufficient to motivate change.[53] Yet people often find narratives more compelling than raw statistics or detailed technical analyses.[54] Narratives can be disproportionately persuasive even amongst individuals who are highly numerate and used to interpreting statistics.[55] The stories embedded in **Being Well Salford's** report are a creative example - their description of how their service works is brought to life with videos from people who have actually experienced it.[56]

Creative Minds describe examples where supporting one of their service users to speak directly to commissioners, practitioners and programme managers has reduced siloed thinking and encouraged a new way of working within the service. Studies have shown that using stories told in the first person are twice as effective at influencing decisions than stories about others.[57] The beneficiaries of person- and community-centred approaches themselves are credible messengers and their testimonials can be highly persuasive.[58]

Stories need not be limited to those told by service users. Storytelling by staff and carers too can have persuasive power.[59] Stories which bridge different narratives (e.g. moving from scepticism about a certain approach, to a new appreciation) can help avoid entrenching resistance to a narrative which challenges an individual's belief system.[60]

Community-based organisations

Provide ownership

'Lifting and shifting' programmes of person- or community-centred approaches from one area to another rarely encourages interventions to spread meaningfully.[61] People have a natural tendency to value their own creations to those of others. This can explain the 'IKEA effect' whereby people value furniture they have built themselves significantly more than that which others (even experts) have made.[62]

In contrast, enabling people to design and adapt their own programmes (without losing the 'hard core' of effective practice at its heart)[63] is likely to increase the degree to which they value those programmes and engage personally with them.[64]

Unlimited Potential and **Inspiring Communities Together** have found that learning sessions during the design-phase of The Salford Together[65] initiatives have been effective at building buy-in and a sense of ownership which is sustained as projects develop. These events have brought older members of the local community into contact with statutory bodies and local councillors. This means that local people are seen as integral to the success of projects (rather than passive recipients) and that commissioners have a meaningful and memorable link to projects from their very early days.

Give commissioners the experience

Commissioners may become more engaged in an approach if they find it easy to call it to mind and have positive personal experience of it.[66]

Some of the positive impacts of person- and community-centred approaches are likely to be difficult for commissioners to experience directly - whether via healthcare datasets (e.g. how many attendances at A&E have there been?) or evaluations (e.g. how much happier/more in control/more hopeful are people feeling?) Evidence indicates that making something easier for commissioners to grasp or picture makes it more likely that it will become adopted more quickly.[67]

For example, **Unlimited Potential** have run a 'timebank showcase' and **Inspiring Communities Together** a 'tech and tea bootcamp', both of which gave commissioners a chance to drop in, see the respective projects in action and hear first-hand stories from local people about their impact. Directly observing the impacts enables commissioners to take persuasive stories back to their colleagues as well as increasing the positive sense that they are making a difference to local people via their commissioning decisions.[68] In both cases, the showcases prompted commissioners to schedule follow-up meetings to establish more joint-working.

Earn trust

Commissioners use reputations of trustworthiness as rules of thumb for assessing the credibility of community-centred organisations.[69] Community-centred organisations with strong reputations are more likely to attract the attention and trust of commissioners. The local commissioners of **Being Well Salford** and **Creative Minds** described a wish to be associated with these organisations, due to their reputation for quality and innovation.

Community-centred organisations can strengthen credibility of their reputations by:

- Maintaining high levels of satisfaction amongst the people and communities they work with. Reputations spread through networks and 'word of mouth'.[70]
- Integrating commissioners into evaluations: **Being Well Salford** have invited the commissioner to attend bi-monthly evaluation meetings where they discuss the successes and challenges of their health coaching service's operation. At first both parties felt this degree of transparency was unusual, but it has meant that the commissioner now feels very in touch with the programme. This has helped build Being Well Salford's credibility as a learning organisation which can be trusted to deliver a sustainable service.
- Developing reliable sources of evidence.[71] **Penny Brohn UK's** emphasis on collecting a range of evaluation and outcome measures on a longitudinal basis and transparently sharing these helps their commissioners develop trust in their service's evidence base.
- Forging partnerships with well-recognised and respected funders. Organisations such as the Big Lottery Fund and Nesta tend to have a 'halo effect' (whereby global judgements are made about something or someone based on positive reception of one or two characteristics).[72] Developing an association with such organisations can increase the recognition that local commissioners have of the service.
- Integrating closely with people that commissioners already trust. **Creative Minds** started inside an NHS mental health trust (South West Yorkshire Foundation Trust) and maintains strong links by being co-located and keeping regular meetings with Trust staff. This close working builds trust and familiarity.

Package evidence appropriately

Evidence and information should be tailored and targeted to the intended audience.[73] **Positively UK**, for example, repackage their evidence carefully depending on the audience. When engaging members of their community they have established that foregrounding the potential to make connections and build a supportive social network 'works'. When engaging clinicians, however, their ability to encourage medication adherence and relieve demand in clinics is highlighted, with greater success.

Clinicians are used to making decisions based on clinical trial evidence. Medical approaches are frequently adopted, even when the proven effect sizes of a given medical treatment are relatively small, or indistinguishable from a non-medical approach. In an example from primary care treatment of depression, there is some evidence that cognitive behavioural therapies (CBT) can be as effective (and cost-effective) as taking antidepressants, with fewer side effects.[74] However, it is rare for person- and community-centred, 'more than medicine' approaches to be presented in direct comparison to medical approaches, even when they are the more attractive option.[75]

Presenting effect sizes of person- and community-centred approaches in a way that clinical practitioners are familiar with may help, although it is unlikely to achieve the whole goal of changing practitioner behaviour. Research has identified that GPs continue to prescribe medications because it is easy, familiar and seen as low risk.[76] For these reasons, changing the presentation of information is only likely to 'work' in combination with other techniques such as those listed in this guide.

Some of the barriers to changing the direct comparison between medical and 'more than medicine' approaches may reflect persistent barriers to rigorous evaluation of the latter. Person- and community-centred approaches face the challenge of neatly isolating the impacts of a programme in the context of complex social system and low levels of data sharing between the statutory sector and community partners.[77] These and other system barriers are discussed elsewhere in the Realising the Value programme's final resources and recommendations.[78]

Spreading person- and community-centred approaches by making it SOCIAL

Spreading change is not only concerned with ease, attractiveness, or even evidence. Sometimes the spread of innovation reflects social processes just as much as the strength of the research.[79]

This section features four examples which draw on social mechanisms of achieving change:

Health and care providers and commissioners	Community-based organisations
Incentivise whole groups	**Connect with champions**
Widen teams and train them together	**Promote via peer networks**

Health and care organisations

Incentivise whole groups

We are often concerned with spreading change beyond innovative 'early adopters'. **The King's Fund** has researched how one commissioning area has been able to incentivise all local GPs to improve together by making 40 per cent of their QOF (Quality and Outcomes Framework) payments contingent on the achievement of improvements at GP practices across the whole Clinical Commissioning Group (CCG).[80] This approach required a strong sense of support and an element of a 'leap of faith' by individual practices.

Once in place this incentive promoted collaborative problem-solving, harnessed an element of peer-pressure and led to greater transparency across GPs. This latter mechanism is likely to have a strong behavioural effect in and of itself - social norm feedback which enables underperforming practices to see that they are doing worse than their peers has been shown to change practitioner behaviour in other studies.[81] Raised levels of competitiveness may also be responsible for driving up performance.[82]

Although not an example from one of Realising the Value's partner sites it is a good example of an innovative approach to spreading new, quality-focused ways of working.

Widen teams and train them together

Social norms are strong determinants of behaviour. Training whole teams may be effective in terms of flipping a cultural 'switch', triggering a process of shared problem solving, consistency of behaviour throughout a service, and movement towards a new way of doing things.[83]

When training teams, practical, demonstrative or experiential training is most effective.[84] The experience of acting out new consultation styles makes them more familiar and readily accessible once the practitioner is back in their usual context.

'Whole teams' include anyone who has a public-facing role.[85] Many roles are relevant here, including administrators, lay supporters, volunteers, care navigators and other non-clinical people across health organisations and other statutory bodies. Recognition of the important practical support that non-clinical individuals provide in order to translate health or wellbeing advice into behaviour change is growing.[86] For **Positively UK**, for example, the clinic's reception team are just one of four routes (including via clinicians, social care coordinators and self-referral) by which people are directed to peer supporters. They may have a more conversational relationship with the people attending clinics which highlights the need for community support more clearly.[87]

With the right training, non-clinical team members can spend time addressing small, practical barriers which stand between people living with long-term conditions and the confidence to self-manage their own health.[88] In some instances, non-clinical services are in fact found to be more effective than contact with traditional healthcare providers, in the area of weight loss, for example.[89] Expanding the workforce or forging partnerships with non-clinical supporters will help health and care organisations achieve person- and community-centred ends.

Community-based organisations

Connect with champions

Well-connected champions of person- and community-centred approaches can help increase the take-up of these innovations because they role-model and nudge their networks to behave differently.[90] Knowing where a champion's passions overlap with a community-centred organisation's mission and keeping them appraised of the latest achievements can enable them to be strong messengers for change.

Creative Minds have developed a strong network of staff who champion creative group approaches and keep this network updated about developments in the projects they support. In doing so, they have increased the numbers of practitioners working in their host NHS mental health trust who offer a person- and community-centred approach to people using the service.

Creative Minds have thereby multiplied the number of creative projects on offer to people who use their services as champion staff become more engaged and volunteer to run creative projects in their own areas. One service manager, for example, repurposed budget which he had allocated to decorating service-user accommodation. Instead of buying in artwork, he invested the funds in resources which could be used by the service-users themselves to make art for their own walls. The reactions of service-users were very positive and the resulting changes in behaviour that the staff observed have meant that this approach has become the new norm for any changes that need to be made to the unit.

Other sites connect with champions by attending their local Health and Wellbeing Board and becoming a member of other relevant local groups.

Promote via peer networks

Peers are powerful messengers because we tend to respond to people who are like us.[91] Accordingly, fellow practitioners are particularly influential in the transfer of innovative practices, doctor to doctor, nurse to nurse, administrator to administrator - particularly if they are also from a similar context to us (although hearing the same message from multiple sources is also likely to add to persuasiveness).[92]

GPs tend to take up similar innovations to their peers in neighbouring practices. Local informal networks of information-sharing appear to be as influential as national guidance within primary care - in one survey 85 per cent of GPs cited 'speaking to other doctors' as the source of where they found out about new ways of doing things, while 56 per cent cited NICE guidance. Even when NICE guidance[93] is widely known about, it may not be enough to shift behaviour in and of itself.[94]

- As well as monitoring outcomes for people participating in their peer-support networks, **Positively UK** surveys clinicians at their clinics. Alongside clinical champions who they partner with, they present the results (illustrating that clinicians have seen positive impacts on their patients) to wider groups of clinicians at conferences. Hearing that others like them have experienced improved outcomes attracts new clinicians who want to benefit in the same way.
- **Being Well Salford** have found that they can tap into these processes across a range of stakeholder groups by partnering with a diverse range of subcontractors. These links enable news of their approach to spread via many networks.
- **Unlimited Potential** have found that linking up neighbouring commissioners can enable change to spread. Commissioners from a next-door patch are likely to be credible sources of information about approaches that work and councillors who have strong grassroots links can be motivators for keeping up with the neighbouring 'competition'.

Spreading person- and community-centred approaches by making it TIMELY

Policy and budgetary cycles matter, as does the strong pull of the present. People respond differently to prompts depending on when they occur.[95]

This section outlines five examples:

Health and care providers and commissioners	Community-based organisations
Incentivise change now	**Identify timely moments in the commissioning cycle**
Make tools timely	
Change mindsets	**Create feedback loops**

Health and care organisations

Incentivise change now

People are biased towards the present - they prefer rewards now rather than rewards in future (even if a delay could result in a disproportionately bigger payout).[96]

The King's Fund cites an example of commissioners providing GP practices with up-front payments for committing to achieving a certain quality standard, rather than receiving a bonus after the fact.[97] Practices receive funding straight away to invest in order to make change happen. If practices cannot demonstrate that they have achieved the change within a given timeframe, or used the investment to fund the necessary improvements, then it must be returned to commissioners.

This example also motivates change by harnessing loss aversion, as well as bias towards the present. Because losses tend to loom larger than gains, the certainty of having to pay back funding motivates practitioners to change quickly (and avoid an imminent loss).[98]

Make tools timely

Tools which support person- and community-centred approaches (such as those described in the *Supporting self-management guide*) can assist practitioners in changing behaviour. If they are not available in the right place at the right time, however, their use and related changes in behaviour may be limited.[99]

In an illustration of this, embedding the use of shared decision-making (SDM) aids like Option Grids[100] has made slow progress, in spite of their low-tech, user-friendly design. Short-form decision-making aids

can provide practitioners with a clear way to support a patient with weighing up different options (and select the one most suited to them) in the context of brief appointment slots. Certain aids have been endorsed by NICE and have high standards of quality assurance.[101] The cost-effectiveness evidence for their use is also compelling – patients who make decisions about treatment with use of an SDM aid are more likely to opt for less invasive (and less costly) forms of treatment than those who do not.[102] Furthermore, option grids in particular lend themselves to local development and a sense of ownership which can increase their use - they have a well-defined structure but can be developed flexibly to reflect the local diversity of local care options.

A contributing factor for their sluggish adoption is that there is no easy way for practitioners to access them in the moment that they are needed by a particular patient in a short consultation.[103] Few have been embedded in an accessible way to GPs' computer systems. Tools must be physically accessible at the right time if they are to be used by practitioners and their wider teams, even where there is high clinical buy-in already.[104]

TOOL:

Shared decision-making aids can be designed in different ways:

- Short-form option grids can be used by practitioners as an aide memoir to prompt a consideration of diverse options
- Long-form, patient-facing shared decision-making (SDM) aids have been developed for over 30 conditions. These can be used by people outside of consultations to reflect on what is important to them and take the time to deliberate between different options. This can be dependent on practitioners signposting people to the tools and supporting those who face digital or literacy barriers to their use.

Change mindsets

Person- and community-centred approaches reflect a certain mindset: that people are capable of development and self-improvement over time (a growth mindset), rather than being stuck in their ways (a fixed mindset). Mindsets can affect the way that people convey encouragement or coaching behaviours.[105] This in turn could help people themselves to develop resilience and persistence when facing self-management challenges.[106]

In one study, mothers who gave their children more praise which recognised the hard work, persistence or strategies their child used to overcome barriers, raised children who had a stronger growth mindset. Parents who do not praise the process a child goes through before reaching an achievement may raise children who are less inclined to persevere in the face of challenges. Similar patterns have been found for teachers and managers.[107]

This matters in the face of the challenge of spreading more person- and community-centred approaches to self-management. If professionals within the system cannot see the potential for themselves or the people they work with to change (and improve) then it will be difficult to make progress.

Crucially, studies indicate that growth mindsets can be taught. In one case, a 90-minute video teaching the principles of a growth mindset increased the number of quality coaching ideas that managers came up with.[108] Whilst these ideas are yet to be applied widely in health settings, initial studies hold promise.[109]

TOOL: https://www.mindsetkit.org/

This resource kit was developed by researchers at Stanford University to provide people with an understanding of mindsets and how to teach people to develop growth mindsets. Whilst it was developed predominantly for teachers and mentors, many of its insights about how to influence people's response to challenges and learning how to do things differently using simple changes to language and instructions are transferable to health.

Community-based organisations

Identify timely moments in the commissioning cycle

Commissioning cycles contain windows of opportunity where new ideas are more likely to gain traction.[110] **Unlimited Potential** have found that participating during early discussions of strategic needs can mean that commissioners become more aware of the localised knowledge of community-based organisations, while those organisations benefit from a deeper understanding of the commissioner's priorities.

Unlimited Potential schedule a day with local commissioners well in advance of any re-tendering process to reflect on their collaboration to date, learn about the commissioner's priorities and consider how to continue working together in future. When the time comes to create new service specifications or enter tender processes, this means that commissioners receive applications from community-based organisations which match their needs closely.

Create feedback loops

Commissioners and practitioners are likely to become more motivated to support a person- and community-centred approach if they have contact with the beneficiaries of the project.[111] Where the connection between their decision to invest in a given approach and subsequent improvement of people's health, wellbeing or quality of life is made very salient, they may even experience better job satisfaction.[112]

Being Well Salford make an effort to feed back to practitioners who signpost their patients into health coaching. With the person's permission, they share updates on their progress towards achieving health and wellbeing goals and let the practitioner know the progress and outcomes (e.g. giving up smoking, becoming more physically active or less socially isolated). They find this is an effective way of embedding person- and community-centred approaches amongst practitioners who are initially resistant.

Conclusion

There is growing interest in applying behavioural insights in simple, inexpensive ways to enhance the spread of health and wellbeing programmes. This publication has identified many small but potentially effective opportunities to adapt and develop new programmes and practice.

The EAST framework - highlighting the power of making things Easy, Attractive, Social and Timely - is a user-friendly schema for thinking about how to spread change. We recommend that champions and leaders use this framework when thinking about how behaviours may spread through the health system.

There is a need to test and extend our understanding of what may work in new contexts, before adapting them and improving them further.[113] Evaluating robustly and learning from iterative spreading attempts will mean we start to build evidence for what works. Incremental improvements will then build our understanding of how to meet this challenge.

Annex: Research process

Researchers from BIT worked with practitioners at each site across five workshops and five days of participant observation to understand their approaches to enabling behaviour change for health and wellbeing. The sites worked closely with BIT to share the evidence base underlying their activities and to shape the content of this guide.

Additionally, researchers shadowed primary care practitioners across three GP surgeries to understand some of the context and pressures experienced by healthcare practitioners at present as they seek to provide person-centred care and connections to the community. We acknowledge that this research was exploratory and does not provide a comprehensive idea of all the settings in which person- and community-centred approaches can be experienced, although it reflects the setting in which the majority of community-based organisations interface with the health sector.[114] Researchers also shadowed an Impact Health Coaching[115] team which was used by one GP practice to understand how the two areas can interact.

Five further workshops were held with the sites alongside the Health Foundation and Voluntary Voices. These workshops were attended by each site's commissioners and wider local stakeholders (including other organisations undertaking similar work with which the sites partner). The main focus of the workshops was a discussion of levers and barriers to the spread of person- and community-centred approaches.

Additionally, interviews were held with 14 expert commissioners and strategic leads across NHS, local authority and third sector settings.

BIT researchers identified themes arising across the interviews, workshops and observations. Where a theme was mentioned more than once by different sites and/or interviewees, this was used to inform literature reviews. Researchers drew together evidence emerging from all these activities into this publication.

Refining the recommended approaches

Drafts of the guide were shared in successive rounds of consultation with the five partner sites, their local networks of commissioners and strategic groups such as the Commissioning for Person-Centred Care group. Drafts were shared, discussed and iterated with practitioners and commissioners. Their feedback collectively shaped the publication.

Endnotes

1. Fisher, E. B., Fitzgibbon, M. L., Glasgow, R. E., Haire-Joshu, D., Hayman, L. L., Kaplan, R. M., Nanney, M.S., and Ockene, J. K. (2011) Behavior matters. 'American journal of preventive medicine.' 40(5), e15-e30.
2. Realising the Value (2016) 'At the heart of health: Realising the value of people and communities.' London: Nesta. http://www.nesta.org.uk/publications/heart-health-realising-value-people-and-communities; Realising the Value (2015) 'How should we think about value in health and care?' London: Nesta. http://www.nesta.org.uk/publications/how-should-we-think-about-value-health-and-care
3. National Voices (2014) 'Prioritising person-centred care: supporting self management – summarising evidence from systematic reviews.' http://www.nationalvoices.org.uk/sites/default/files/public/publications/supporting_self-management.pdf; Willard-Grace, R., Chen, E. H., Hessler, D., DeVore, D., Prado, C., Bodenheimer, T. and Thom, D. H. (2015) Health coaching by medical assistants to improve control of diabetes, hypertension, and hyperlipidemia in low-income patients: a randomized controlled trial. 'The Annals of Family Medicine.' 13(2), 130-138.
4. Interviews with Dr Dimple Vyas, Dr Katie Coleman and Dr Karen Eastman conducted as part of the Realising the Value Programme; Kidd, L., Lawrence, M., Booth, J., Rowat, A. and Russell, S. (2015) Development and evaluation of a nurse-led, tailored stroke self-management intervention. 'BMC health services research.' 15(1), 1.
5. See the other resources in the Realising the Value Programme www.realisingthevalue.org.uk; de Silva, D. (2011) 'Helping people help themselves: A review of the evidence considering whether it is worthwhile to support self-management.' Horne, M., Khan, H. and Corrigan, P. (2013) 'People powered health: health for people, by people and with people.' London: Nesta.
6. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) 'How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.' 1-424. London: NHIR.
7. Mullainathan, S. and Shafir, E. (2013) 'Scarcity: Why having too little means so much.' Macmillan.; Gourville, J. T. and Soman, D. (2005) Overchoice and assortment type: When and why variety backfires. 'Marketing science.' 24(3), 382-395.
8. 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
9. Kahneman, D. and Lovallo, D. (1993) Timid choices and bold forecasts: A cognitive perspective on risk taking. 'Management science.' 39(1), 17-31.
10. Kahneman, D. (2011) 'Thinking, fast and slow.' Macmillan.
11. Samuelson, W. and Zeckhauser, R. (1988) Status quo bias in decision making. 'Journal of risk and uncertainty.' 1(1), 7-59.
12. Bull, D., Bagwell, S., Weston, A. and Joy, I. (2016) 'Untapped potential: Bringing the voluntary sector's strengths to health and care transformation.' London: The Richmond Group of Charities. https://richmondgroupofcharities.org.uk/sites/default/files/aw_ncp_report_-_untapped_potential_-_single_pages.pdf
13. The Behavioural Insights Team (2014) 'EAST: Four simple ways to apply behavioural insights.' London: BIT. http://www.behaviouralinsights.co.uk/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf
14. Cabinet Office and Insitute for Government (2010) 'MINDSPACE: Influencing behaviour through public policy.' London: Cabinet Office. http://www.instituteforgovernment.org.uk/sites/default/files/publications/MINDSPACE.pdf
15. www.realisingthevalue.org.uk
16. Realising the Value (2016) 'At the heart of health: Realising the value of people and communities.' London: Nesta. http://www.nesta.org.uk/publications/heart-health-realising-value-people-and-communities;
17. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) 'How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.' London: NCCSDO. 1-424.; Norton, M. I., Mochon, D. and Ariely, D. (2011) 'The 'IKEA effect': When labor leads to love.' Harvard Business School Marketing Unit Working Paper, (11-091).
18. Haynes, L., Goldacre, B. and Torgerson, D. (2012) 'Test, learn, adapt: developing public policy with randomised controlled trials.' London: Cabinet Office, Behavioural Insights Team. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62529/TLA-1906126.pdf
19. Marteau, T., Ogilvie, D., Roland, M., Suhrcke, M. and Kelly, M. (2011) Judging nudging: can nudging improve population health? 'BMJ.' 2011;342:d228.
20. Marmot, M. (2010) 'Fair society, healthy lives.' Inequalities in health: Concepts, measures, and ethics, 282.
21. www.realisingthevalue.org.uk
22. Realising the Value (2016) 'At the heart of health: Realising the value of people and communities.' London: Nesta. http://www.nesta.org.uk/publications/heart-health-realising-value-people-and-communities
23. Pawson, R. and Tilley, N. (1997) 'Realistic evaluation.' London: SAGE Publications Ltd.
24. Liott, S.J., Taylor, S.M., Cameron, R. and Schabas, R. (1998) Assessing Public Health Capacity to Support Community-Based Heart Health Promotion: The Canadian Heart Health Initiative, Ontario Project (CHHIOP) 'Health Education Research.' 1998;13(4):607–22.

25. Local Government Association (2016) 'Just what the doctor ordered Social prescribing – a guide for local authorities.' London: LGA. http://www.local.gov.uk/documents/10180/7632544/L16-108+Just+what+the+doctor+ordered+-+social+prescribing+-+a+guide+to+local+authorities/f68612fc-0f86-4d25-aa23-56f4af33671d
26. Fennell, M.L. and Warnecke, R.B. (1988) 'The Diffusion of Medical Innovations: An Applied Network Analysis.' New York: Plenum.; Siriwardena, A. N. (2010) Why do GPs prescribe psychotropic drugs when they would rather provide alternative psychological interventions? 'British Journal of General Practice.' 60(573), 241-242.
27. And their partners Social Adventures, also based in Salford.
28. Bettinger, E. P., Long, B. T., Oreopoulos, P. and Sanbonmatsu, L. (2012) The role of application assistance and information in college decisions: Results from the H&R Block FAFSA experiment. 'The Quarterly Journal of Economics.' 127(3), 1205-1242.
29. Rolfe, H. (2010) 'Learning to take risks, learning to succeed.' London: Nesta. https://www.nesta.org.uk/sites/default/files/learning_to_take_risks_learning_to_succeed.pdf
30. Bandura, A. (1977) Self-efficacy: toward a unifying theory of behavioral change. 'Psychological review.' 84(2), 191.; Dillard, J. P. (1991) The current status of research on sequential-request compliance techniques. Personality and Social Psychology Bulletin, 17(3), 283-288.
31. Gobet, F., Lane, P., Croker, S., Cheng, P., Jones, G., Oliver, I. & Pine, J. (2001). Chunking mechanisms in human learning. TRENDS in Cognitive Sciences, 5(6), 236-243.
32. Freedman, J.L. & Fraser, S.C. (1966). Compliance without pressure: The foot-in-the-door technique. 'Journal of Personality and Social Psychology.' 4, 195-202.
33. Mullainathan, S. and Shafir, E. (2013) 'Scarcity: Why having too little means so much.' Macmillan.; The Behavioural Insights Team (2014) 'EAST: Four simple ways to apply behavioural insights.' London: BIT. http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf
34. The Behavioural Insights Team (2014) '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; Institute for Government, MINDSPACE. http://www.instituteforgovernment.org.uk/sites/default/files/publications/MINDSPACE.pdf
35. Mullainathan, S. and Shafir, E. (2013) Scarcity: Why having too little means so much. Macmillan.
36. The Behavioural Insights Team (2014) '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
37. Stokes, K., Barker, R. and Pigott, R. (2014) 'Which doctors take up promising ideas? New insights from open data'. London: Nesta. http://www.nesta.org.uk/publications/which-doctors-take-promising-ideas-new-insights-open-data#sthash.FL5iepvo.dpuf; The Health Foundation (2014) 'Ideas into action: person-centred care in practice What to consider when implementing shared decision making and self-management support.' London: The Health Foundation. http://www.health.org.uk/sites/default/files/IdeasIntoActionPersonCentredCareInPractice.pdf; Rolfe, H. (2010) 'Learning to take risks, learning to succeed.' London: Nesta. https://www.nesta.org.uk/sites/default/files/learning_to_take_risks_learning_to_succeed.pdf
38. Townsend, W. (2013) Innovation and the perception of risk in the public sector. 'International Journal of Organizational Innovation.' (Online), 5(3), 21.; Addicott, R. and Ham, C. (2014) 'Commissioning and funding general practice: making the case for family care networks.' London: King's Fund. Helping Patients, 153, 2811-2.; The Health Foundation (2014) 'Ideas into action: person-centred care in practice What to consider when implementing shared decision making and self-management support.' London: The Health Foundation. http://www.health.org.uk/publication/ideas-action-person-centred-care-practice; Denis, J. L., Hébert, Y., Langley, A., Lozeau, D. and Trottier, L. H. (2002) Explaining diffusion patterns for complex health care innovations. 'Health care management review.' 27(3), 60-73.
39. Kahneman, D. and Tversky, A. (1979) Prospect theory: An analysis of decision under risk. 'Econometrica: Journal of the Econometric Society.' 263-291.; Stokes, K., Barker, R. and Pigott, R. (2014) 'Which doctors take up promising ideas? New insights from open data.' London: Nesta. http://www.nesta.org.uk/publications/which-doctors-take-promising-ideas-new-insights-open-data#sthash.FL5iepvo.dpuf
40. Rothman, A. J. and Salovey, P. (1997) Shaping perceptions to motivate healthy behavior: The role of message framing. 'Psychological Bulletin.' 121, 3–19.; Townsend, W. (2013) Innovation and the perception of risk in the public sector. 'International Journal of Organizational Innovation.' (Online), 5(3), 21.; Addicott, R. and Ham, C. (2014) 'Commissioning and funding general practice: making the case for family care networks.' London: King's Fund. Helping Patients, 153, 2811-2.; The Health Foundation (2014) 'Ideas into action: person-centred care in practice. What to consider when implementing shared decision making and self-management support.' London: The Health Foundation. http://www.health.org.uk/publication/ideas-action-person-centred-care-practice
41. Kahneman, D. and Lovallo, D. (1993) Timid choices and bold forecasts: A cognitive perspective on risk taking. 'Management science.' 39(1), 17-31.
42. Bunt, L. and Leadbeater, C. (2012) 'The Art of Exit.' London: Nesta. Expert interviews conducted as part of the Reaslising the Value programme.
43. Casebourne, J. (2014) 'Why motivation matters in public sector innovation.' London: Nesta. http://www.nesta.org.uk/sites/default/files/why_motivation_matters_in_public_sector_innovation.pdf
44. Thompson, M. and Walter, F. (2016) Increases in general practice workload in England. 'The Lancet.'
45. Casebourne, J. (2014) 'Why motivation matters in public sector innovation.' London: Nesta. http://www.nesta.org.uk/sites/default/files/why_motivation_matters_in_public_sector_innovation.pdf; 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.
46. Ryan, R. M. and Deci, E. L. (2000) Intrinsic and extrinsic motivations: Classic definitions and new directions. 'Contemporary Educational Psychology.' 25(1), 54-67.; Casebourne, J. (2014) 'Why motivation matters in public sector innovation.' London: Nesta. http://www.nesta.org.uk/sites/default/files/why_motivation_matters_in_public_sector_innovation.pdf

47. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) 'How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.' 1-424. London: NCCSDO.
48. The Innovation Unit (2012) 'COPD Care Checklist: Putting data in the hands of patients to drive care quality and reduce hospital admissions.' London: The Innovation Unit. http://www.innovationunit.org/sites/default/files/COPD%20Care%20Checklist%20Report.pdf
49. Stacey, D., Légaré, F., Col, N.F., Bennett, C.L., Barry, M.J., Eden, K.B., et al. (2014) Decision aids for people facing health treatment or screening decisions (Review). The Cochrane Database Of Systematic Reviews.; de Silva, D. (2012) 'Helping people share decision making: a review of evidence considering whether shared decision making is worthwhile.' London: The Health Foundation.
50. Sheffield Hallam, Centre for Regional Economic and Social Research (2014) 'Evaluation of the Rotherham Social Prescribing Pilot.' http://www.shu.ac.uk/research/cresr/ourexpertise/evaluation-rotherham-social-prescribing-pilot; King, E., Taylor, J., Williams, R. and Vanson, T. (2013) 'The MAGIC programme: evaluation. An independent evaluation of the MAGIC (Making good decisions in collaboration) improvement programme.' London: The Health Foundation.
51. Based on expert interviews with Dr Dimple Vyas, Dr Karen Eastman and Dr Katie Coleman which informed this guide.
52. This was reported by the commissioners of Realising the Value partner sites at commissioner workshops.
53. Allen, M. and Preiss, R. W. (1997) Comparing the persuasiveness of narrative and statistical evidence using meta-analysis. 'Communication Research Reports.' 14(2), 125-131.
54. Bartel, C. and Garud, R. (2009) The role of narratives in sustaining organizational innovation. 'Organization Science.' 20(1): 107-117.; Breckon, J. and Dodson, J. (2016) 'Using Evidence: What works? A discussion paper.' London: Alliance for Useful Evidence. http://www.alliance4usefulevidence.org/assets/Alliance-Policy-Using-evidence-v4.pdf
55. Stewart, R. E. and Chambless, D. L. (2010) Interesting practitioners in training in empirically supported treatments: Research reviews versus case studies. 'Journal of Clinical Psychology.'66(1), 73-95.
56. https://www.beingwellsalford.com/report/
57. Winterbottom, A., Bekker, H. L., Conner, M. and Mooney, A. (2008) Does narrative information bias individual's decision making? A systematic review. 'Social science & medicine.' 67(12), 2079-2088.
58. NHS England (2015) 'Improving Experience of Care through people who use services.' NHS England. https://www.england.nhs.uk/wp-content/uploads/2013/08/imp-exp-care.pdf
59. NHS Midlands (2014) 'What's the story? Storytelling within the NHS (Midlands and East) Part One: Realist Evaluation Study Findings.' NHS Midlands and East. https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2014/09/pat-stories-eval-part1.pdf
60. Lord, C. G., Ross, L. and Lepper, M. R. (1979) Biased assimilation and attitude polarization: The effects of prior theories on subsequently considered evidence. 'Journal of personality and social psychology.' 'Political Behavior.' 32(2), 303-330.; Graves, C. (2015) Why Debunking Myths About Vaccines Hasn't Convinced Dubious Parents. 'Harvard Business Review.' https://hbr.org/2015/02/why-debunking-myths-about-vaccines-hasnt-convinced-dubious-parents
61. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.' 1-424. London: NCCSDO. ; Hallsworth and Rutter (2011) 'Policy Making in the Real World.' London: Institute for Government.
62. Norton, M. I., Mochon, D. and Ariely, D. (2011) 'The 'IKEA effect': When labor leads to love.' Harvard Business School Marketing Unit Working Paper, (11-091).
63. van Klei, W.A., Hoff, R.G., van Aarnhem, E.E., et al. (2012) Effects of the introduction of the WHO 'Surgical Safety Checklist' on inhospital mortality: a cohort study. 'Annals of Surgery.' 2012;255:44-9; Denis, J.L., Hebert, Y. Langley, A., Lozeau, D., Trottier, L.H. (2002) Explaining Diffusion Patterns for Complex Health Care Innovations. 'Health Care Management Review.' 2002;27(3):60–73.
64. The Health Foundation (2014) 'Ideas into action: person-centred care in practice. What to consider when implementing shared decision making and self-management support.' London: The Health Foundation. http://www.health.org.uk/publication/ideas-action-person-centred-care-practice; Rogers, E.M. (1995) 'Diffusion of Innovations.' New York: Free Press; Ovretveit, J., Bate, P., Cleary, P., Cretin, S., Gustafson, D., McInnes, K., McLeod, H., Molfenter, T., Plsek, P., Robert, G., Shortell, S., Wilson, T. (2002) Quality Collaboratives: Lessons from Research. 'Quality and Safety in Health Care.' 2002;11:345–51.
65. http://www.salfordtogether.com/
66. Tversky, A. and Kahneman, D. (1973) Availability: A heuristic for judging frequency and probability. 'Cognitive psychology.' 5(2), 207-232.; Grant, A. M. (2011) How customers can rally your troops. 'Harvard Business Review.' 89(6), 96-103.
67. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) 'How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.' London: NCCSDO.
68. Grant, A. M. (2011) How customers can rally your troops. 'Harvard Business Review.' 89(6), 96-103.
69. Bull, D., Bagwell, S., Weston, A., and Joy, I. (2016) 'Untapped potential: Bringing the voluntary sector's strengths to health and care transformation.' London: The Richmond Group of Charities. https://richmondgroupofcharities.org.uk/sites/default/files/aw_ncp_report_-_untapped_potential_-_single_pages.pdf, although there is reason to think that this trust may be declining: http://nfpsynergy.net/slidezone/trust-oct-15
70. The Behavioural Insights Team (2015) 'EAST: Four simple ways to apply behavioural insights.' London: BIT. http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf
71. Breckon, J. and Dodson, J. (2016) 'Using Evidence: What works? A discussion paper.' London: Alliance for Useful Evidence. http://www.alliance4usefulevidence.org/assets/Alliance-Policy-Using-evidence-v4.pdf
72. Nisbett, R. E. and Wilson, T. D. (1977) The halo effect: Evidence for unconscious alteration of judgments. 'Journal of personality and social psychology.' 35(4), 250.

73. Breckon, J. and Dodson, J. (2016) 'Using Evidence: What works? A discussion paper.' London: Alliance for Useful Evidence. http://www.alliance4usefulevidence.org/assets/Alliance-Policy-Using-evidence-v4.pdf
74. Kuyken, W., Hayes, R., Barrett, B., Byng, R., Dalgleish, T., Kessler, D., Lewis, G., Watkins, E., Brejcha, C., Cardy, J. and Causley, A. (2015) Effectiveness and cost-effectiveness of mindfulness-based cognitive therapy compared with maintenance antidepressant treatment in the prevention of depressive relapse or recurrence (PREVENT): a randomised controlled trial. 'The Lancet.' 386(9988), pp.63-73.
75. For examples to the contrary see Ornish, D., Brown, S. E., Billings, J. H., Scherwitz, L. W., Armstrong, W. T., Ports, T. A., et al., (1990) Can lifestyle changes reverse coronary heart disease?: The Lifestyle Heart Trial. 'The Lancet.' 336(8708), 129-133.; Ornish, D., Weidner, G., Fair, W. R., Marlin, R., Pettengill, E. B., Raisin, C. J., et al., (2005) Intensive lifestyle changes may affect the progression of prostate cancer. 'The Journal of urology.' 174(3), 1065-1070.; Wadden, T. A., Berkowitz, R. I., Womble, L. G., Sarwer, D. B., Phelan, S., Cato, R. K., et al., (2005) Randomized trial of lifestyle modification and pharmacotherapy for obesity. 'New England Journal of Medicine.' 353(20), 2111-2120.; Dickinson, H. O., Mason, J. M., Nicolson, D. J., Campbell, F., Beyer, F. R., Cook, J. V., et al., (2006) Lifestyle interventions to reduce raised blood pressure: a systematic review of randomized controlled trials. 'Journal of hypertension.' 24(2), 215-233.; Figure 4 in https://www.povertyactionlab.org/sites/default/files/publications/2012.3.22-Deworming.pdf
76. Siriwardena, A. N. (2010) Why do GPs prescribe psychotropic drugs when they would rather provide alternative psychological interventions? 'British Journal of General Practice.' 60(573), 241-242.
77. Bull, D., Bagwell, S., Weston, A., and Joy, I. (2016) 'Untapped potential: Bringing the voluntary sector's strengths to health and care transformation.' London: The Richmond Group of Charities. https://richmondgroupofcharities.org.uk/sites/default/files/aw_ncp_report_-_untapped_potential_-_single_pages.pdf
78. www.realisingthevalue.org.uk
79. Denis, J. L., Hébert, Y., Langley, A., Lozeau, D. and Trottier, L. H. (2002) Explaining diffusion patterns for complex health care innovations. 'Health care management review.' 27(3), 60-73.
80. Addicott, R. and Ham, C. (2014) 'Commissioning and funding general practice: making the case for family care networks.' London: The King's Fund. 'Helping Patients.' 153, 2811-2.
81. This study that aimed to reduce inappropriate antibiotic prescribing by GPs. Providing social norm feedback was found to have a significant impact on behaviour. The top 20 per cent of GP practices for antibiotic prescribing in each region of England were sent a letter informing them that they prescribe more than their peers in the same area and provided easy to follow advice about how to bring this down. Nationwide, this reduced prescription rates by 0.85 percentage points compared to a control group. Hallsworth, M., Chadborn, T., Sallis, A., Sanders, M., Berry, D., Greaves, F., Clements, L. and Davies, S. C. (2016) Provision of social norm feedback to high prescribers of antibiotics in general practice: a pragmatic national randomised controlled trial. 'The Lancet.'
82. Ashraf, N., Bandiera, O. and Jack, K. (2012) 'No Margin, no Mission? A Field Experiment on Incentives for Pro-Social Tasks.' CEPR Discussion Paper 8834; Kullgren, et al., (2013) Individual-Versus Group-Based Financial Incentives for Weight Loss: A Randomized, Controlled Trial. 'Annals of Internal Medicine.' 158 (7), 505-514.
83. Siriwardena, A., Middlemass, J. B., Ward, K. and Wilkinson, C. (2008) Drivers for change in primary care of diabetes following a protected learning time educational event: interview study of practitioners. 'BMC Medical Education.' 8(1), 1.; The Health Foundation (2014) 'Ideas into action: person-centred care in practice. What to consider when implementing shared decision making and self-management support.' London: The Health Foundation. http://www.health.org.uk/publication/ideas-action-person-centred-care-practice
84. Stokes, K., Barker, R. and Pigott, R. (2014) 'Which doctors take up promising ideas? New insights from open data.' London: Nesta. http://www.nesta.org.uk/publications/which-doctors-take-promising-ideas-new-insights-open-data#sthash.FL5iepvo.dpuf ; Breckon, J. and Dodson, J. (2016) 'Using Evidence: What works? A discussion paper.' London: Alliance for Useful Evidence. http://www.alliance4usefulevidence.org/assets/Alliance-Policy-Using-evidence-v4.pdf; Knowles, M.S., Holton, E.F. and Swanson, R.A. (2011) 'The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development.' 7th Edn. Amsterdam: Elsevier Science.;
85. NHS England (2014) 'An Implementation Guide and Toolkit for Making Every Contact Count: Using every opportunity to achieve health and wellbeing.' NHS England. https://www.england.nhs.uk/wp-content/uploads/2014/06/mecc-guid-booklet.pdf; Ovretveit, J. et al., (2002) Quality Collaboratives: Lessons from Research. 'Quality and Safety in Health Care.' 2002;11:345–51.
86. Realising the Value (2016) 'At the heart of health: Realising the value of people and communities.' London: Nesta. http://www.nesta.org.uk/publications/heart-health-realising-value-people-and-communities
87. Positively UK (forthcoming, 2016) 'Qualitative Evaluation of Peer Navigators Service.'
88. Health Foundation (2014) 'Person-centred care: from ideas to action Health Foundation summary and analysis.' London: The Health Foundation. http://www.health.org.uk/publication/person-centred-care-ideas-action; Horne, M., Khan, H. and Corrigan, P. (2013) 'People powered health: health for people, by people and with people.' London: Nesta. https://www.nesta.org.uk/sites/default/files/health_for_people_by_people_and_with_people.pdf
89. Jolly, K., Lewis, A., Beach, J. et al., (2011) Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial. 'BMJ.' 343:d6500.; Jebb, S.A., Ahern, A.L., Olson, A.D. et al., (2011) Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. 'The Lancet.' Oct 22:3378(9801):1485–92.
90. Bodenheimer, T. (2007) 'The science of spread: how innovations in care become the norm.' California Health Care Foundation. The Behavioural Insights Team (2015) 'EAST: Four simple ways to apply behavioural insights.' London: BIT. http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf
91. Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. and Peacock, R. (2004) 'How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation.' 1-424.; Institute for Government, MINDSPACE. http://www.instituteforgovernment.org.uk/sites/default/files/publications/MINDSPACE.pdf; Esposo, S. R., Hornsey, M. J. and Spoor, J. R. (2013) Shooting the messenger: Outsiders critical of your group are rejected regardless of argument quality. 'British Journal of Social Psychology.' 52(2), 386-395

92. Harkins, S. G. and Petty, R. E. (1981) The multiple source effect in persuasion: The effects of distraction. 'Personality and Social Psychology Bulletin.' 7(4), 627-635.

93. Stokes, K., Barker, R., Pigott, R. (2014) 'Which doctors take up promising ideas? New insights from open data.' London: Nesta. http://www.nesta.org.uk/publications/which-doctors-take-promising-ideas-new-insights-open-data#sthash.FL5iepvo.dpuf

94. Gough, K.L.M. et al., (2013) A national survey exploring choice of antibiotic prophylaxis for caesarean section: What impact have the NICE guidelines had? 'International Journal of Obstetric Anesthesia.' 2013; Poster Presentation at Obstetric Anaesthesia 2013 Conference.

95. The Behavioural Insights Team (2015) 'EAST: Four simple ways to apply behavioural insights.' London: BIT. http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf; Institute for Government, MINDSPACE, http://www.instituteforgovernment.org.uk/sites/default/files/publications/MINDSPACE.pdf

96. O'Donoghue, T. and Rabin, M. (1999) Doing it now or later. 'American Economic Review.' 89(1), 103-124.

97. Addicott, R. and Ham, C. (2014) 'Commissioning and funding general practice. Making the case for family care networks.' London: The King's Fund. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/commissioning-and-funding-general-practice-kingsfund-feb14.pdf

98. Kahneman, D. (2011) 'Thinking, fast and slow.' Macmillan.

99. Elwyn, G., Rix, A., Holt, T. and Jones, D. (2012) Why do clinicians not refer patients to online decision support tools? Interviews with front line clinics in the NHS. 'BMJ Open.' 2(6), e001530.; McCartney, M., Treadwell, J., Maskrey, N. and Lehman, R. (2016) Making evidence based medicine work for individual patients. 'BMJ.' 353, i2452.

100. http://sdm.rightcare.nhs.uk/pda/

101. https://www.nice.org.uk/news/article/helping-people-with-af-make-informed-choices-about-their-treatment

102. O'Connor, A.M., Stacey, D. (2005) 'Should Patient Decision Aids (PtDAs) be Introduced in the Health Care System?' Copenhagen: World Health Organization Health Evidence Network.; Coulter, A. and Collins, A. (2011) 'Making shared decision-making a reality: no decision about me, without me.' London: The King's Fund.

103. Health Foundation (2014) 'Implementing shared decision making Clinical teams' experiences of implementing shared decision making as part of the MAGIC programme.' London: The Health Foundation. http://www.health.org.uk/publication/implementing-shared-decision-making#sthash.Bd30sCBm.dpuf; McCartney, M., Treadwell, J., Maskrey, N. and Lehman, R. (2016) Making evidence based medicine work for individual patients. 'BMJ.' 353, i2452.

104. Health Foundation (2014) 'Implementing shared decision making Clinical teams' experiences of implementing shared decision making as part of the MAGIC programme.' London: The Health Foundation. http://www.health.org.uk/publication/implementing-shared-decision-making#sthash.Bd30sCBm.dpuf

105. Dweck, C. S. (2006) 'Mindset.' New York, NY: Random House; 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.

106. 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; The Behavioural Insights Team (2016) 'Making the change: Behavioural factors in person- and community-centred approaches to health and wellbeing.' London: Nesta. Published as part of the Realising the Value Programme.

107. Dweck, C. S. (2016) The Remarkable Reach of Growth Mind-Sets. 'Scientific American Mind.' 27(1), 36-41.

108. 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; For further explanation see the accompanying theoretical report to this guide: 'Making the change: Behavioural factors in person- and community-centred approaches to health and wellbeing.'

109. 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.

110. Breckon, J. and Dodson, J. (2016) 'Using Evidence: What works? A discussion paper.' London: Alliance for Useful Evidence. http://www.alliance4usefulevidence.org/assets/Alliance-Policy-Using-evidence-v4.pdf

111. Grant, A. M., Campbell, E. M., Chen, G., Cottone, K., Lapedis, D. and Lee, K. (2007) Impact and the art of Organizational Behavior and Human Decision Processes, 103(1), 53-67.motivation maintenance: The effects of contact with beneficiaries on persistence behavior. 'Organizational Behavior and Human Decision Processes.' 103(1), 53-67.

112. Wrzesniewski, A. and Dutton, J. E. (2001) Crafting a job: Revisioning employees as active crafters of their work. 'Academy of Management Review.' 26, 179 –201.; Tims, M., Bakker, A. B. and Derks, D. (2013) The impact of job crafting on job demands, job resources, and well-being. 'Journal of occupational health psychology.' 18(2), 230.

113. The Behavioural Insights Team (2013) 'Test, Learn, Adapt: Developing Public Policy with Randomised Controlled Trials.' London: BIT. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62529/TLA-1906126.pdf

114. Bull, D., Bagwell, S., Weston, A. and Joy, I. (2016) 'Untapped potential: Bringing the voluntary sector's strengths to health and care transformation.' London: The Richmond Group of Charities. https://richmondgroupofcharities.org.uk/sites/default/files/aw_ncp_report_-_untapped_potential_-_single_pages.pdf

115. http://www.horshamandmidsussexccg.nhs.uk/your-health/health-coaches/

About Realising the Value

Realising the Value is a programme funded by NHS England to support the NHS Five Year Forward View. It is led by Nesta and the Health Foundation, working in partnership with Voluntary Voices (made up of National Voices, Regional Voices, NAVCA and Volunteering Matters), The Behavioural Insights Team, PPL and the Institute of Health and Society at Newcastle University. 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.

Realising the Value

Led by: The Health Foundation, Nesta

Funded by: NHS England

In partnership with: The Behavioural Insights Team, National Voices (People shaping health and social care), navca (local focus national voice), PPL, regional voices, Volunteering Matters, Newcastle University