A Question of Behaviours

Why delivering care integration and managing acute demand depends as much on changing behaviour as new systems and structures

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iMPOWER is a 50-strong team specialising in behavioural insight, commissioning and demand management for local public services. We are also the UKs leading advisor to adults and children's social care services

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- Innovation in demand management and preventive strategies
- Co-production with our clients, reducing dependency on our help and building the skills of public servants

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EXECUTIVE SUMMARY

This report addresses two connected challenges

- **The increasing dependency on acute settings and urgent care, particularly for the elderly**
- **The positive agenda to integrate care in home and community settings**

Our evidence shows that structural 'big system' change alone will not work. Behavioural norms for professionals and the public are stronger than any new system can create and need to be tackled directly.

The results of 6 months of research are startling. They show that trust, relationships, behaviour and experience are the real drivers of positive outcomes. Yet we are in danger of losing sight of the behavioural dimension as we become entangled with system and structure change which could cause more disintegration than the integration it aims to achieve.

We have found:

- **Most GPs (56%) think their relationship with social care is poor or very poor**
- **Health professionals dramatically underestimate the impact of their behaviours**
- **Less than half (46%) of the elderly population have the confidence they know how to access the health and care system**
- **The behaviour of many patients and users create perverse outcomes for them and the system, driving up demand and cost**

£3.8bn has been allocated to fund integration and additional resources continue to be poured into overstretched urgent and acute care. The risk is that this money will be used to fund yet more structural change which cannot succeed without behaviour change of all actors in the system.

The time is right to make behavioural insight centre stage in the challenge to shift the locus and effectiveness of care.

There are four simple steps to change behaviour:

1. Locating Behavioural Leadership

Many leaders understand its importance but aren't familiar with the key tools they need

Pioneer applications have been heavily biased towards structure, system and initiative based solutions

2. Identifying Behavioural Segments

Most NHS organisations and Councils risk shaping care based on provider logic. Disease, clinical risk and cost must be balanced with behavioural segmentation

3. Discovering Behavioural Insights

In this report we illustrate eight behavioural insights from our research. But localities need to own and discover insights based on a refined contextual understanding of their care demand and supply side

4. Changing Behaviours

In this report we identify 15 behaviours, for professionals and the public alike, that if changed or reshaped would bring benefits in

- Demand management
- Cost
- Outcomes
- Performance
- Patient and user experience

A QUESTION OF BEHAVIOURS

This white paper is based on:

- A survey of 200 older people
- A review of relevant literature
- 3 filmed focus groups with older people
- A friends and family survey
- Our 'Home Truths' surveys of over 600 GPs
- 40 interviews of leaders and managers in the care and health services
- iMPOWER'S portfolio of 50 behavioural change studies in a range of public services

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DOES BEHAVIOUR MATTER TO OUR NHS AND CARE SERVICES?

"Discontent arises from a knowledge of the possible, as contrasted with the actual." **Nye Bevan, Founder of the NHS, In Place of Fear, 1952**

Is reform, as we understand it, enough?

We start with a clear statement of belief; the NHS and social care services are not broken but can be made better. The health and care economy in the UK has provided and continues to provide a panoply of largely cherished and good quality support to huge numbers of people. To ensure it is able to continue to provide this support it must however, evolve, improve and change. This short report is an narrative that offers a new approach to that evolution, improvement and change. By moving the current debate beyond the traditional focus of large structural and system change to one that places behavioural insight, attitude, motivation and human interaction at its heart we can develop a new way to improve the quality of care, build better professional relationships and make the health service more sustainable.

Our premise is that the health economy has been overly prey to big structural and system changes since its inception in 1946, particularly in more recent years. These have yielded some positive results but have consistently fallen short of both the ambitions of our political masters and the professionals responsible for delivering care. As recently as June 2013, Chair of the BMA, Dr Mark Porter, described the latest NHS structural reforms as creating *"a Byzantine system that nobody wants."*[1] Whether or not we all share this particular perspective, there is an emerging consensus we must look past the structures we have continually created and recreated and focus much more on the people that make care work.

1 http://www.bmj.com/content/346/bmj.f4097

Have we ever had sufficient, direct focus on behaviours?

The issue of behaviours in the health service is not a modern one. As far back as 1956 Arthur Blenkinsop MP noted in the Jameson Working Party report that *"co-operation between General Practitioners and health visitors… is lacking in many cases at the moment."*[2] Fast forward half a century and one of our senior interviewee's stated *"It's in the integration and the hand offs that things still go wrong."*[3] Clearly we are still wrestling with the same challenges around behaviour and integration. This serves to highlight the crucial point that even with new systems and structures in place, if professionals and patients don't use them the way we intended, the systems and structures won't work.

> ***"It's in the integration between services and the handoffs that go wrong. We can sometimes provide excellent care as we define and organise it, but in so doing utterly miss the context and needs of the patient/user"*** **Interview responder[4]**

"Behavioural insight and change can help simplify a complex problem…"

Care integration is complex. The King's Fund estimate that there are 175 different definitions of care integration currently in circulation. Even if we can agree at a high level what care integration is, we are dealing with a web of specialisms and needs which need to be perfectly calibrated to ensure the right answer for a patient/user is produced. In such a complex, people based system, there is one component that can be simplified and made to hold the complexity together – human behaviour. **That is why delivering a more integrated care economy must and will fail if it is based on large structural and system change alone. It must be accompanied by an equally significant focus on the behaviours of the individuals involved in them. To do so is not to add effort – but to simplify the challenge.**

"…but behaviours can be stubborn"

Attitudes or mind-sets, especially when motivated by values, can be exceptionally hard-wired. Our societal notion of the acute hospital is pervasive. Simply providing a different package of services locally won't completely change the magnetism of acute hospital and its white-coated

2 http://nhstimeline.nuffieldtrust.org.uk/
3,4 Interview response

consultants. So, if we want to shift the locus of care, we also need to shift the mind-set of millions of people. But whether it is a societal mind-set, the behaviour of particular clinicians or the engagement with a patient/user, our understanding of behaviour, what drives it - and how to change it – is exceptionally weak. If we recognise this flaw, there is a rich seam of potential for us to discover. If we don't we will suffer the history of reform in the NHS – which is that people have failed to behave in the way the 'reformers' intended.

> ***"There is a kind of psychological contract that older people in particular have with acute hospitals – possibly an historical affinity with the building as the place where their problems can ultimately be solved"*** **Interview responder[5]**

Will care integration work?

Our priority must be to shift the focus of care away from the default of secondary to the most appropriate level; in so doing to remove the gaps, duplications and perverse incentives that bedevil our current system of care and leave patients and users stranded in the nether world of our current structures and silos. We believe that health care professionals recognise the prescience of 'now'. This is a moment to embrace change. We are discontented with the system because, as Nye Bevan noted, we contrast the possible with the actual. The choice is clear, a change that will work or a change that won't.

Our health and care economies are now seized by the need to integrate. Politically there has never been a stronger imperative for integration in England – and we see a furious urgency in many of the plans and ideas being developed to meet the challenge. The Integration Transformation Fund and the Pioneer sites add tangibility to exhortation – and as austerity bites, it is difficult to see a credible alternative that meets the fiscal squeeze for Town Halls and health commissioners alike.

Yet it might not actually work – or at least be significantly less effective than we imagine. We see the evidence in the Integration Pioneer bids of the need for structural models and services initiatives far beyond a recognition and understanding of culture and behaviour. That at least suggests we should warn ourselves that if or when it doesn't work as we plan, it is likely those troublesome 'people' that will be to blame.

THE STARTING POINT: BEHAVIOURAL LEADERSHIP

Is it OK to have a behavioural agenda?

Behavioural dynamics are often hidden in plain sight. And if they are seen, we often lack the ability to latch on to a tried and trusted change mechanism. That's not because we are deficient leaders or managers, but because the tools aren't well practiced and obvious. Policy documents, business cases, pathway reviews, target operating models – somehow they don't fit the complexity of how to positively shift human behaviour.

The first step is to acknowledge it is OK to have a behavioural agenda. An inappropriate attendance at A&E, over-referral from primary to secondary care, a lack of basic information passed between the NHS and social care, the poorly designed discharge, the appointment no-shows - these are all symptoms of behavioural dynamics we can and should have a right to change. Interestingly, these are all issues the health and care system experiences now – and can change now – without resort to more major structural change.

> ***"we need to do a lot of work up stream with the patients in order to ensure that they understand and are confident on pre hospital resources".***
> **Interview responder[6]**

For leaders in the health and care system, want to set out two simple ways of seeing this

1. **The three pillars of care integration**
2. **The paradox of integration reform**

5,6 Interview response

The three pillars of care integration

The three pillars are a way of conceptualising the different approaches to change within complex organisations and services and are derived from our literature review on integration. As stated previously, our central thesis is that the health service has been the victim of numerous 'Big System' integration approaches. These organisational changes have the capacity to consume all of our attention for uncertain or questionable levels of benefit. Of course we hope the big changes we make will have at least some 'trickle down' effects, but such is the effort and upheaval involved, it is rare we consciously drive through the intended benefits. If we can move beyond the big system (Pillar one) in our planning and change design we get into 'Professional behaviours' where we believe at least a third of our time and money should be spent unlocking the passion and dedication of staff in the health and care system. Finally, we move into the 'patient, user and community' pillar which offers the most tangible benefits in terms of demand reshaping/reduction. However, often users and patients are the paupers in programmes of change – rarely have we seen a third of change effort focused on this component. In times of austerity demand management becomes ever more important as a tool for public service

sustainability. So if we don't ensure two thirds of our effort is focused on the behaviour of patients, users and professionals we are **missing** a golden opportunity to sustain services into the medium and long term.

Our health and care system is characterised by very strong professional boundaries which will, and have, persisted beyond structural change. This is the failure structures/processes over behaviours, in truth most significant programmes of change have barely broken out of the first pillar. We don't say that people haven't seen pillars two and three. Rather, the somewhat primal nature of the issues covered in pillar one become all-consuming for the top managers. The disruption of money flows, accountability and power structures personalise the challenge and create irrational side effects. One consistent theme is a retreat from collaboration. If our end goal is a more co-produced service offering then clearly we need to address this.

By bringing all three approaches into sync we can neutralise a significant amount of the displacement effect cause by big system integration. This requires a comprehensive understanding of the behavioural landscape of our services and organisations. It also makes the programme of change significantly more likely to succeed and produce far better outcomes for patients and users.

Based on the evidence we have gathered it is clear that the behaviours, attitudes and motivations of professionals and citizens are as much, if not more, a determinate of success in significant programmes of change than structures or systems. Despite this being the reality we have not acted upon it. Leaders will need to acknowledge that the current major policy shift to integrate health and social care is not unique in its current neglect of the behavioural dynamic. We only need to look back to Baroness Serota in 1970 proclaiming that *"our basic purposes are to unite the National Health Services and to integrate its separate services locally"* or Sir Keith Joseph in 1971 arguing that the government's proposals *"for the NHS offer a great, and indeed a new, opportunity for a partnership with local authorities,"* to know that if structural reform alone was enough, we'd have cracked it decades ago.[7] One reason that such efforts of collaboration and integration have been unsuccessful is that our efforts have created a paradox.

7 http://nhstimeline.nuffieldtrust.org.uk/

The paradox of integration reform

> ***"The development of integration may even be destructive….since professionals as well as managers tend to defend their territories when these are believed to be threatened"***
>
> **"A decade of integration and collaboration: the development of integrated care in Sweden."** **Ahgren and Axelsson, February 2011**

To be clear, we are not suggesting urgent care reforms and care integration efforts should be halted. But when we consider the development of integration and the experience of similar endeavours it is obvious there are risks. This is especially true in the current climate where many professionals and managers can perceive moves to integrate care as being a smokescreen for cost shunting and spending reductions.

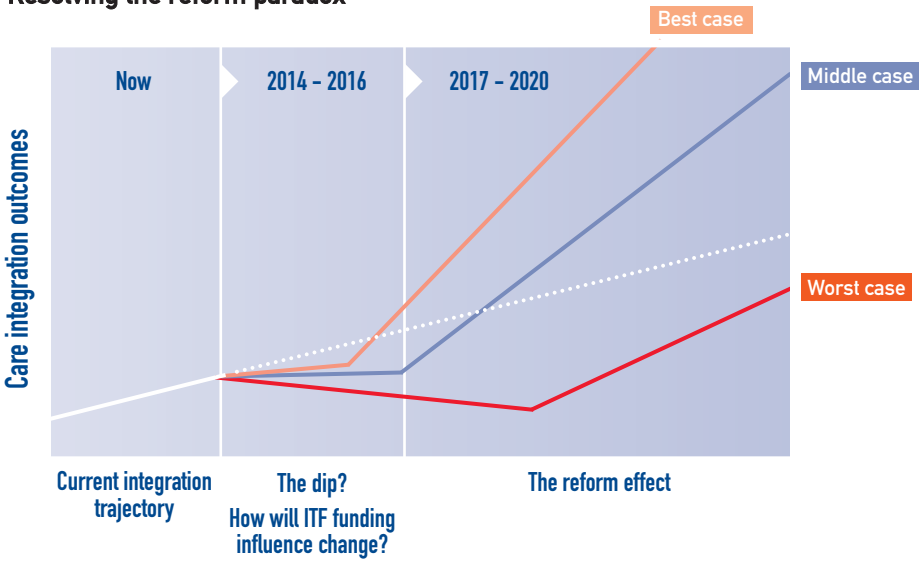
In light of the current financial context we must acknowledge this risk. Where managers and clinicians feel threatened, they may retreat from collaboration. To compound this factor, leadership and management energy is diverted to the structure change and away from the sharp end of patients, users, practice and behaviours. Hence, we are confronted with a paradox. Our push to create a more collaborative health and care offering is made less likely by our some of our actions to create it. This is the result of our lack of appreciation for behavioural drivers when engaging in such a significant process of reform.

The following chart sets out more positively what is at stake – it conceptualises a major integration programme which will take two years to achieve – and suggests a 'performance dip' in integration is probable whilst the upheaval takes place and new systems settle down. For health and care reformers, the challenge is to manage the dip to be as flat and short as possible, whilst maximising the uptick of improvement thereafter.

> ***"Everyone sees it through their own risk spectrum' Unless we can put our interests and professions to one side and look at the whole picture, we can't integrate. Frankly some people get this and some don't".*** **Interview responder[8]**

8 Interview response

Resolving the reform paradox



The Integration Transformation Fund (ITF) provides a significant opportunity to accelerate integration but our initial assessment suggests behavioural change is not being addressed. As a result we think even with ITF money the reform paradox is liable to transpire.

The message for leaders – identify and manage behaviours

Whether local integration plans have partnership, restructuring, financial flows or locality experimentation at their heart, the message for leaders is straightforward. Without assessing how behaviours in the system, from patients/users and professionals alike, the risk of failure is magnified.

There are tools and approaches which can apply measurement and rigour of implementation to the challenge. Some, such as behavioural economics, are relatively novel. But many, such system leadership and organisation development, are well within existing political and managerial toolkits.

The first step for leaders is to appreciate the significance of the issue. Without this appreciation professional behaviour and patient/user engagement is likely to remain overlooked and the potential for care integration unfulfilled.

IDENTIFYING BEHAVIOURAL SEGMENTS

To optimise care integration and concurrently manage acute demand, there are a number of groups of people whose behaviours we want to influence. They can be summarised at a high level as

i. **Patients and users**
ii. **Prospective patients and users**
iii. **Friends and families**
iv. **Front-line professionals and carers**
v. **Leaders and managers**

But quite plainly, these segments are insufficiently targeted to be of use below the high level. Naturally we want deeper and more specific segments.

Moving from provider based notions of who people are

The power of behavioural insight is in challenging old notions of how we see the world, and beginning to find new ones. There is no significant orthodoxy about how this should be done, but a starting point is a realisation that we have a particular and pervasive way of looking at populations centred on things that are not about the person or their experience, namely:

- **NHS disease/condition, multiples of**
- **Care need type e.g. learning difficulties, older adults**
- **Level of need e.g. substantial, critical**
- **Unit cost/financial mechanism**
- **Care context or setting (primary, intermediate, secondary, tertiary, home)**
- **Professional e.g. geriatrician, physiotherapist**
- **Pathway stage (e.g. emergency call, A&E, inpatient)**
- **Method/innovation e.g. telehealth, multi-agency team,**

It's not wrong for us to use these typologies, far from it, but where we start in looking at and changing behaviours needs to be slightly different. It is when we reframe the problem outside of the norms of our current service patterns that the potential for transformational change is optimised.

Towards people and experience based insight

Behavioural insight work with these groups will require leaders to search more deeply. Just as the best in the private sector understands its customers and staff are individuals, in an NHS and care context we need to appreciate that different patients and users are also driven in varying degrees by other characteristics, including:

- Core values and motivations
- Common root causes of conditions or presenting issues
- Care experience
- Behaviour
- Demographic factors
- Levels of capability
- Familial structures
- Ethnicity
- Media Influences

Segmenting by Values – The Sandwell Pilot

In our survey of 200 older people in Sandwell we segmented the respondents into 3 broad value types, using the Values Mode tool[9]. We found the responses of each segment to the same cues and questions to be very different. The values types for each respondent where derived from a short values questionnaire, and we categorised the groups into:

- Pioneers: Inner directed drive, often want to explore and innovate
- Prospectors: Outer directed drive, guided by external influences, seeking esteem
- Settlers: Driven by security, identity, belonging

The case study clearly demonstrated differences in response to a variety of questions, as set out opposite.

9 Value Modes, a Maslovian segmentation tool based on attitudes and motivations © Cultural Dynamics

Key behavioural differences by values segment

	Pioneers	Prospectors	Settlers
% in each group	28% of the group are Pioneers – a significant group but slightly behind the national average. As society changes, we expect this group to increase	48% - a very surprisingly large number. Prospectors will often be more demanding of their public services and want to see they are getting good value – especially in comparison to others	24% - a surprisingly low number. This group is more likely to trust their local services, but also more keen to see predictability and reliability in their services. We would expect much higher numbers in the general population of older people
Levels of trust	The Pioneer group has the lowest level of trust (63%) in their local health and care services. It shows many will win trust when they are engaged in the right way for them	The Prospector group also has lower levels of trust (64%) in their local services –they will need the offer clarified for them to evaluate the 'deal'	The Settler Group has higher levels of trust (75%). But there may be a gap between what the Settler expects and the services that are available
Confidence	Only 47% of Pioneers are confident they can access the right healthcare when they need it	Prospectors are least confident they can access what they need (42%) – this would be analogous to the value type in wanting to evaluate the offer	Settlers are the most confident (50%) but there is generally low confidence across the groups
Influences	All groups are influenced most strongly by GPs and hospital doctors Pioneers rely much more on the views of NHS professionals than the other groups (but not social care)	All groups are influenced most strongly by GPs and hospital doctors Prospectors are more strongly influenced by Media and Advertising than the other groups	All groups are influenced most strongly by GPs and hospital doctors Settlers rely more than other groups on the views of informal carers, social workers and friends/neighbours
Urgent care risk	LOW - likely to explore alternatives	HIGH - prospectors may 'game' the system	VERY HIGH - can suffer in silence until a point of crisis
Integration appetite	HIGH - strongly independent but will also have high engagement expectations	HIGH - will enthusiastically engage if the offer is credible	LOW - will be suspicious of novelty and may not desire empowerment

Our Sandwell research has been an experiment in using population segments – in this case organised by age and values - to identify behavioural insights. It raises questions for us such as:

- Should be consider values and behaviours in consulting with patients and users?
- Should our responses to issues such as A&E, delayed discharge and Winter Pressures be nuanced by values?
- How can we use 'strongest influencers' of value types, like families, as means of influencing key initiatives such as telehealth?

Population segmentation in health has understandably focused on disease and clinical risk. Which is effective – in its own terms. But if we have an agenda to change behaviour within the system and for patients and users (as we do in the context of care integration), more sophisticated behavioural segmentation will be needed.


AMBULANCE

DISCOVERING BEHAVIOURAL INSIGHTS

"We need to redefine the culture of having a 'right to the NHS' without taking any responsibility for yourself." **Interview responder[10]**

This chapter is not the last word on behavioural insight but rather provides example insights that can be generated by adopting a behaviour-led approach.

We offer a selection of these examples where some of the hidden truth of behavioural insight has been uncovered in our research. They cover not just patient interactions with services but also inter-professional relationships within the health economy. We chose these distinct examples as they offered a range wide enough to look at not just behaviours but also, attitudes and motivations.

"A&E, they know where it is, they (older people) know it's always open, they know they will get treated, can see and feel a hospital as a tangible thing."
Interview responder[11]

1. Most older people (54%) aren't confident in accessing the health and care system.

Lack of confidence in using the health and care system partly explains why A&E and acute services are under such pressure. Levels of public confidence should be an indicator that all health and care economies measure and manage.

We can do things to drive this percentage upwards. For example, the role of the children of older people in acting as their adviser is significantly over looked; as is the 'prospective' patient segment of older people.

10, 11 Interview response

2. Prospective elderly patients and users have different values which create different expectations

Clearly elderly patients represent a significant constituency for the NHS and there are a number of challenges we face in helping to change behaviours. One stark example raised during our interview process was the usage of bed days. At the end of 2011 the Kings Fund noted that 70% of hospital bed days are occupied by emergency admissions and that 80% of admissions who stay longer than two weeks are over 65's. They argue that an emphasis on alternative pathways for older people would help to reduce hospital bed use.[12]

Whilst estimates vary, it is clear from the evidence that many of these bed days are avoidable. The King's Fund aren't alone in arguing for a more targeted focus on older people's admissions and lengths of stay in acute settings.

However, to tackle issues where older people make up a large part of demand we must begin to understand their drivers and motivations. What shapes their hospital attendance? Is there own behaviour any part of it? And if so, what are the influences? GP? Other local service professionals? Local advertising? Friends and family? The paucity of service in a primary/community setting? Trust in a professional? By exposing this behavioural insight we can see a more detailed picture of their perceptions and in turn, what ultimately drives their actions.

The success of self-care, telehealth, personal budgets and other personalisation and control initiatives depends fundamentally on understanding the values of patients and users.

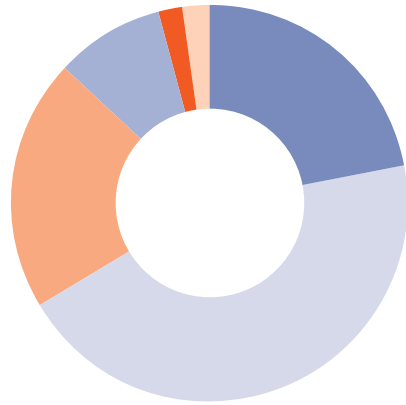
12 http://www.kingsfund.org.uk/sites/files/kf/data-briefing-emergency-bed-use-what-the-numbers-tell-us-emmi-poteliakhoff-james-thompson-kings-fund-december-2011.pdf

3. Prospective patients and users have high levels of trust

From a survey of 200 older people 67% said they trusted their local health and care services (agree and strongly agree).[13]

To what extent do you agree with the following statement: I trust my local health and care services – I know I will only need to go to an acute hospital for my most major or urgent needs

Strongly agree	22%
Agree	44.5%
Somewhat agree	20.5%
Somewhat disagree	9%
Disagree	2%
Strongly disagree	2%



Depending on your perspective, 67% satisfaction is either a ringing endorsement or a worrying loss of trust. But the points here are more nuanced:

- Levels of trust will vary by area and behavioural segment. Knowing where trust is highest and lowest and being able to measure trends in segments could be critical information in delivering integration
- We know that for doctors and the NHS, there is a cultural pre-disposition to satisfaction. Healthwatch have isolated this factor brilliantly in their recent annual report, showing dichotomies in what we say, and what we really think. Despite 72% satisfaction with care services, healthwatch says 1 in 3 of us are concerned about patient safety and 94% of us think health and social care could be improved

By understanding patient and user values care teams can better identify where people are unecessarily deferential or accepting at the risk of their real needs not being met.

13 iMPOWER Older People's Survey (200 responders)

"Whether we are visiting A&E or require meals on wheels, the problem is the same. Few of us know what to expect from our care.

Just seeing ourselves as having rights changes the game. It gets us thinking differently, asking different types of questions and helps us demand the standard of treatment and care we deserve.

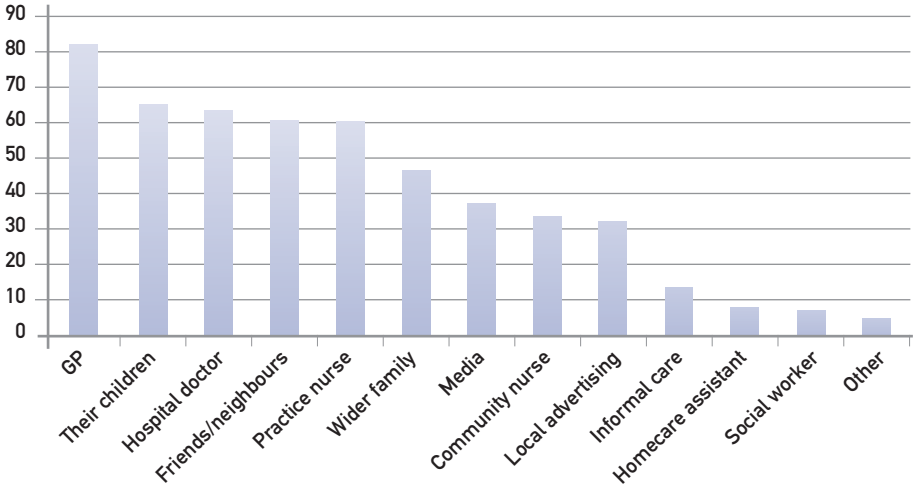
We all need to stop acting like grateful patients and care users, and start to see ourselves as savvy consumers, insisting on our right to safe, dignified and high quality care."

Katherine Rake, Chief Executive, Healthwatch

4. Families and GPs are the biggest influencers of older people in making healthcare access choices

Despite being a culturally independent group, older people just like any other demographic, are influenced by the individuals and the world around them. As part of our older people's survey we asked whether the following groups were an influence on their health choices.[14]

How influential are the following in determining the health and care services you use?



14 iMPOWER Older People's Survey (200 responders)

We can see that GPs are the most trusted individuals (84%) when it comes to an older person assessing their health choices. This was reinforced strongly by the focus groups which showed all older people placing a high degree of trust and respect in their local GP. Interestingly, friends and neighbours (62%) and children (67%) rank closely for second place alongside hospital doctors (65%) and practice nurses (61%) in terms of influence on an elderly patient or user.

This insight reinforces the appropriateness of putting GPs at the centre of recent policy. Our Home Truths[15] programme has shown clearly that GPs are more influential than social workers even where it is a social care issue or choice to be explored. This may be welcomed by some, but the higher the influence, the higher the whole system responsibility.

Whether it is too easy to refer or not, a sustainable integrated care system needs to understand how choices are influenced. Without an understanding of how frail and vulnerable people are guided in their choices our ability to change the system as a whole will be more limited.

The significant influence of families and friends is interesting and worth exploring. Amongst many elderly people they operate a form of 'community triage' and unless correct information is held by their neighbours, friends and family, it operates badly. One example from the focus groups highlighted the story of an elderly woman who having cut her finger, discussed the severity with neighbours, and in the end went to A&E as opposed to her local surgery. Supply side was trumped by demand side.

"It is just too easy for a GP to pick up the phone and have someone admitted." **Interview responder[16]**

Most emerging integration plans place the role of GPs at the heat of integrated care, but the role of families acting as informal advisors to older people is relatively poorly understood and exploited.

15 Home Truths is now live in 13 localities. For more information please go to www.impower.co.uk/en/home-truths-update-442.html
16 Interview response

5. GPs don't know enough about social care, and don't trust what they do know

Whilst we have been fairly robust at measuring the relative trust citizens have in professionals we have been less adept at measuring the levels of trust between professionals themselves. As part of our methodology in the iMPOWER programme Home Truths, we surveyed and spoke with over 600 GPs. Our work in this programme's pilots (13 localities across the UK) largely focused on the relationship between GPs and social care services.

We began here as this represented the most tangible professional link in the journey to an integrated health and social care model. From our work, the overarching message from GPs has been, we would value a better relationship with social care but as it stands, it's not great. The numbers from a sample of over 600 GPs starkly bear this out.

56% of GPs believe their relationship with social care is poor or very poor

47% of GPs felt they were a better assessor of need for residential care than social services

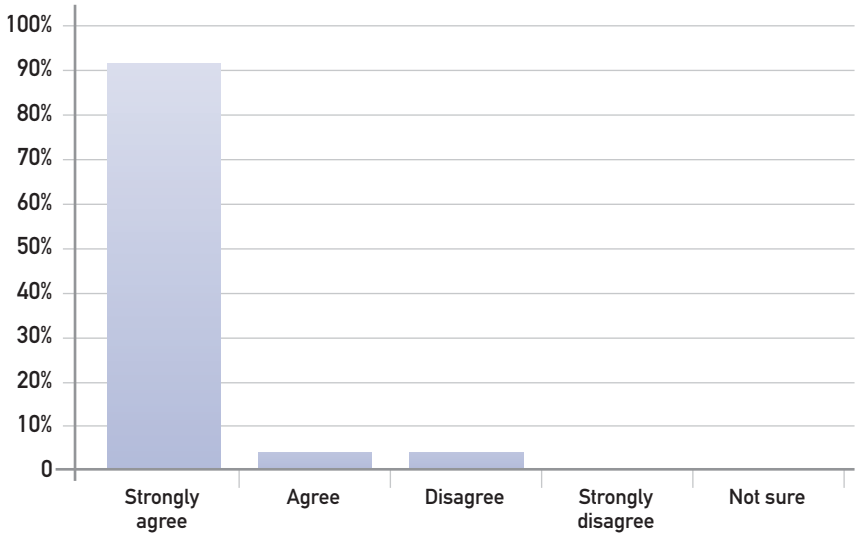
Only 50% of GPs trusted hospital discharge teams to make decisions in the best interests of their patients.[17]

This is a behavioural issue we can and should address immediately. There are responsibilities on both sides of the equation, for GPs and for local authorities. However, GPs to social care is one of dozens of critical professional relationships, health economies should be auditing.

17 http://www.impower.co.uk/public/upload/fichiers/152/impowerhometruthsupdatejune2013.pdf

6. But GPs know their relationship with social care is important, and want it to change

Would you value a better relationship with social services?



Most tellingly in this research, once we had established that trust was not strong between professionals there was a significant impact on knowledge and behaviours. Despite the vast majority of adult social care directors we interviewed saying that they were very proud of the telecare service they offered to residents, 59% of GPs stated that there were *"no telecare services available in their area".* So this significant service offering from the local authority hadn't even registered with the GP as a possible referral choice. Combine this with the fact that nearly half (46%) of GPs said they thought reablement services were either unsatisfactory or very poor and you begin to develop a clearer understanding of the trust deficit that exists between these two sets of professionals. Ultimately, the perception of performance within this relationship is arguably more important than actual performance.[18]

18 http://www.impower.co.uk/public/upload/fichiers/152/impowerhometruthsupdatejune2013.pdf

The work highlighted to us the fact that even within professions there was a wide variety of opinion. Beyond the overwhelming desire to develop a stronger relationship the drivers and motivations were quite individual to those questioned. This brings us back to developing stronger individual relationships amongst professionals. The attitudes of professionals in this relationship are having an adverse effect on the care of patients and users. Again, we are moved to ask, would structural reform address the problem of professional relationships being under-developed? The answer remains, no.

There is a latent behavioural goodwill to break out of current silos, giving us optimism that behaviour change is attainable

7. There are competing and sometimes contradictory demands on primary care

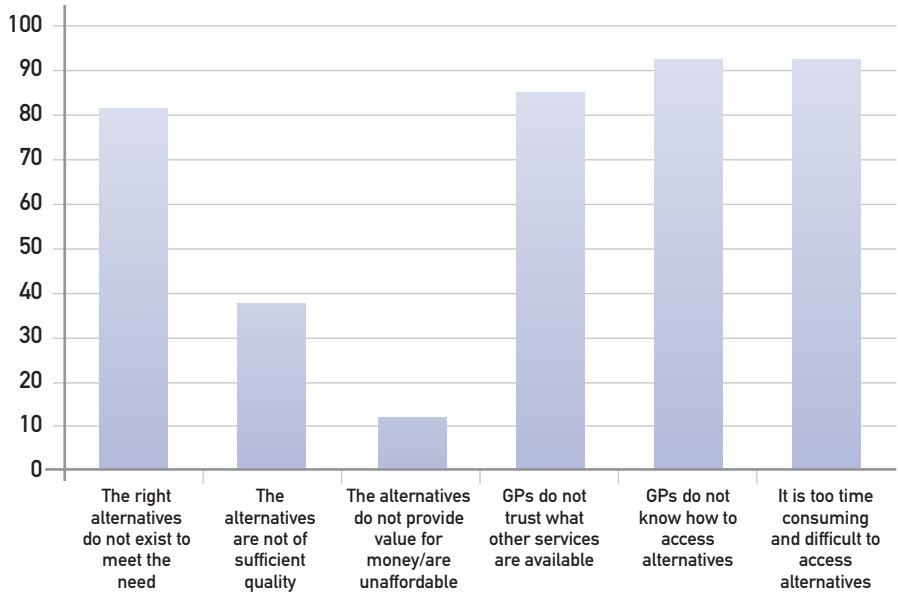
A significant focus of the professional interviews we undertook for this report made some strong assertions about the role of GPs and local health services in a patient's journey between primary and secondary care. The conceptual gap between the two sectors was reinforced, with the GPs seeing rising demand being driven by hospitals trying to generate income, whilst hospital staff tended to see general practice as too variable in quality. However, whether as the driver of demand or as its recipient, there was a general agreement about the centrality of GPs in providing a holistic view of a person's care.[19]

"We have lost that continuity of ones relationship with the GP, and we need to get that back." **Interview responder [20]**

The perceived breaking in link between professional and locality manifests itself in a number of ways. Focus group attendees referred to the high GP turnover they experienced at their surgeries as one reason.[21] Our interview responders also suggested that the lack of knowledge on alternative local service offerings was an issue. More than 90% of interview responders agreed that GPs do not maximise the use of alternatives to acute care for the elderly. When asked what they thought this was driven by there were a variety of competing ideas.

19 Focus group
20 Interview response
21 Focus group

Why aren't alternatives to acute hospitals maximised?[22]



Professionals identified the lack of trust GPs have in alternative provision. However, the most prominent reasons noted were concerned with access to alternatives, time and complexity. These drivers, we suggest, can be arrested by the building of stronger relationships between GPs and fellow professionals.

When looking at the relationship between GPs and professionals through behavioural lenses you can begin to see the refraction of decisions/behaviours. For example in the Home Truths programme many professionals felt that GPs were in part responsible for the over-referral of

> ***"The relationship between primary and secondary care needs to improve. We're too disconnected, to the public we seem like one system, anyone inside know the opposite is true."*** **Interview responder[23]**

22 Interview questionnaire
23 Interview response

elderly patients to residential care.[24] On the face it this appears to only have a service implication for the local authority in question, however multiple interviewees expressed serious concern about behaviours in residential and nursing homes. All too often they will *"refer to hospitals with problems they can solve themselves."*[25] . *"The culture of nursing homes pushes people towards 'blue light' incidents"*.[26]

> ***"Nursing and residential care homes are increasingly being risk averse and are more likely to call an ambulance rather than deal with the patient in situ"***
> **Interview responder[27]**

Referral patterns are substantially a feature of behaviour and attitude, not of structure or system. When thinking behaviourally the interconnectivity of professional relationships becomes more pronounced and also something more open to influence.

Every system based on providers and commissioners has a 'supply side' and a 'demand side' and it is the resolution of the tension between these that determines how well that system works. In the NHS, the supply side is compartmentalised, and so there are big challenges in recognising the advantages of integrated care. We need to twin track in influencing supply side maturity but also stimulating behaviour on the demand side.

We risk building a new supply of primary and community care without resolving the behavioural issues that will continue to push people to acute settings

24 http://www.impower.co.uk/public/upload/fichiers/152/impowerhometruthsupdatejune2013.pdf
25, 26, 27 Interview response

8. There is a powerful magnetism towards hospitals and hospital doctors

The NHS has a strong emotional resonance with the British public. In particular, doctors are seen as the most trusted professionals in the country.[28] Whilst this has engendered an almost universally positive perception of the NHS as an institution it has also bought with it some unwelcome baggage. This is strongly felt in the dissection of services between primary and secondary care. Often there is the sense that we stagger between two competing extremes, either the link is so strong between them that the lines of accountability become blurred or the distance is so great patients often feel like they are flung from one system to another. In either scenario the ultimate loser is the patient who is left feeling that no one truly 'owns' their care.

> ***"Some patients do not feel they have been cared for until they see a doctor."*** **Interview responder[29]**

Whilst this dysfunction can be in part attributed to the health system we must also recognise that the individual patient has a responsibility. There is still a lack of understanding on the side of patients as to what is the appropriate level for them to receive services, ultimately leading to unnecessary attendance at inappropriate access points. There is therefore a challenge in ascribing the *"need to change the mind-set about what should be provided…in a hospital."*[30]

> ***"Public perceptions need to change – too many people hold outdated views about healthcare, either what is offered or how we deliver it."*** **Interview responder[31]**

In particular 88% of interview responders either agree or strongly agree that the acute hospital had a psychological pull for patients.[32] Professionals almost universally agreed that this was driven by primarily a lack of knowledge and understanding about the alternatives available by patients and families (94%) and secondarily they felt the 'guilt of families' was also a major driver (76%). Perhaps the most interesting point is that professionals did not feel that their own messaging or encouragement was that strong of a driver with only 40% of interview responders noting it.[33]

28 http://www.ipsos-mori.com/Assets/Docs/Polls/Feb2013_Trust_Topline.PDF
29, 30, 31 Interview response
32, 33 Interview questionnaire

Discovering more behavioural insights

There is clearly a need for health and care economies to have much greater understanding of people and their drivers and attitudes. If family and friends are considered a significant driver of demand their behaviours are of consequence to the health service. If professionals don't comprehend the power of their influence in the whole system then we have a major issue. If the values of patients and users are good predictors of their behaviour then we need to discover much more. And if we have a relationship with our health and care services then we have a right and responsibility to change that relationship in new contexts.

We do not draw national level behavioural insights from the survey and focus work group we have performed for this White Paper. We would rather that localities used the ideas to discover more about how their local organisations, professionals and patients/users interact with their health and local care systems. The results and insights will be different in each place.

We believe the evidence of our work and of others demonstrates beyond doubt that behaviours and a significant component of achieving the dream of health and care integration. If leaders don't recognise and manage the demand side, in particular via behavioural insight, we believe the dream cannot be made reality.

CHANGING BEHAVIOURS

"We need to do a lot of work upstream with the patients in order to ensure that they understand and are confident on pre hospital resources."
Interview responder[34]

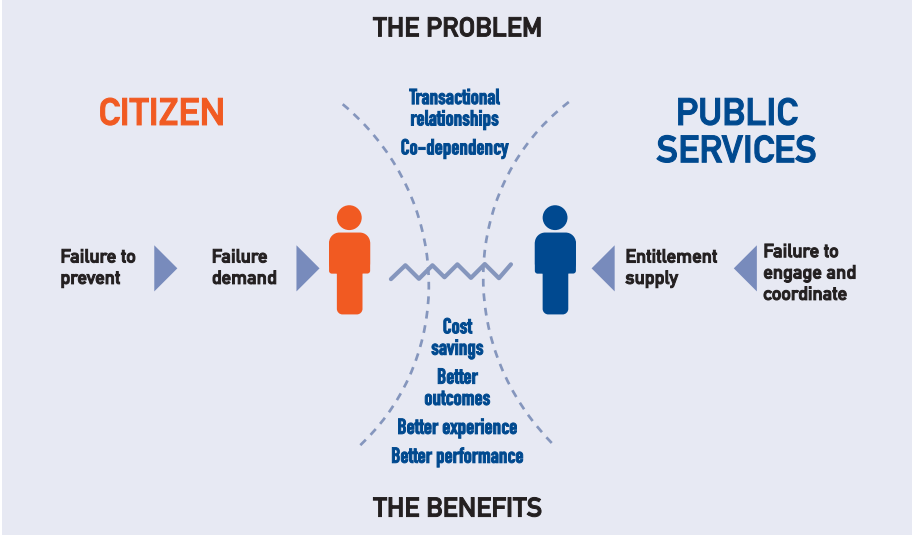
The benefits of changing behaviour are significant, tractable and tangible. Changing behaviour in the context of care integration allows us to make four key things happen:

1. **We will be able to manage demand better**
2. **We will avoid costs and save money**
3. **We will improve outcomes and performance**
4. **We will change the patient and user experience**

These benefits are rarely discrete. iMPOWER has delivered over 50 behavioural change projects, in 20 different areas of public services, predominantly in personal services. Almost all involve at least some renegotiation of fractured 'contracts' between the citizen and public services. In this renegotiation, multiple benefits are delivered. When changes in behaviour are secured, demand is changed. This in turns unlocks cost savings and performance improvements. The startling fact is that in all cases, outcomes and experience improve. This is because high demand is very commonly a function of a broken contract between the patient or user and public services, as the following exhibit shows:

34 Interview response

The broken contract: The power of behaviour change in delivering better outcomes and reducing costs



Changing behaviour in the context of care integration – getting started

> ***"The analysis shows that the people who are in A&E need to be there as this is the only place they can get to. Once there, they are on a conveyer belt and can't get off."*** **Interview responder[35]**

The structure of this White Paper mirrors the approach we believe all localities attempting integration should consider:

35 Interview response

Key steps in changing behaviours

Step 1	Locating behavioural leadership	The vision and plans for integration require behaviour change at their heart. There is a positive challenge to examine how existing plans can be improved Applications to the Integration Transformation Fund provide a particularly good opportunity to demonstrate behavioural leadership
Step 2	Identifying behavioural segments and specific behaviours	There is an opportunity to look at local populations differently. Many areas will be carrying out joint social care and population analysis already. The risk is that a disease and clinical risk focus will not be supported by smart behavioural analysis. Our review of a sample of Pioneer applications suggests most don't mention demand management
Step 3	Discovering behavioural insights	Discovering behavioural insight depends on thinking differently about how we do projects and create change in public services. The notion of our traditional planning, business process, service pathway, operating model and business case tools needs to be replaced with • Data-rich problem identification • Innovative methods of engagement with behavioural segments • Co-production with users and patients • Root cause analysis • System mapping • Trial design
Step 4	Changing behaviour	Pragmatism is key in changing behaviour. The outcome of a changed behaviour is critical, not the method to achieve it. However, the following have worked well in iMPOWER's portfolio of projects: • Use of behavioural economics tools in designing changes • The use of filmed insight with patients and users to achieve change for staff • Organisation development tools and skills including training, change agency, coaching and action research • The adoption of rigorous trialling prior to system wide rollouts

"The NHS needs to move from a risk-averse culture to a risk-aware culture."
Lord Adebowale

"…they either don't, can't or won't look at the services when you come out of hospital." **Interview responder[36]**

What behaviours do we need to change in the context of care integration?

"You could walk in with your head under your arm and he would ask you what you had come for. He never looked at you face to face, all he did was look at his computer screen." **Focus Group Participant[37]**

Our research highlighted a very wide range of behaviours which, if changed, could deliver very significant benefits. Again, these will be very different by locality but we believe they can be a starting point. They are a mix of positive behaviours to encourage and negative behaviours to prevent. They cover both demand side and supply side actors:

36 Interview response
37 Focus group

15 Behavioural Issues We Need to Change

Professional Behaviours

System myopia	Through our behaviours we can actually accentuate the gaps between the many systems patients often have to navigate. The temptation to focus entirely on your own part of the process and then pass the problem on will always be there when you have an organisation that pays little attention to the behaviour, attitudes and motivations of individuals. The answer to this is not to process engineer better relationships; instead through co-production we can build capacity across systems which will help to change cultures as well as behaviours
Co-ordination mind-set	At key points in a care process (such as hospital discharge) the whole system and the whole person needs are not considered fully and professionals don't coordinate effectively. We have collectively known this for some time – it is therefore a cultural issue and not (entirely) one of best practice business process
Whole system leadership	Whole system leadership has significant potential to make a big difference. Budget holders and professionals will act territorially if they see their leaders do so. Positively they will act collaboratively if the cues and signals are more open and collegiate.
territoriality	We will see sharp increases in territoriality as care integration plans develop. It is hugely affected by leadership and cannot be tackled effectively without the right leadership cues.
Blanket assumptions	Statements that start 'my patients want' or 'the frail elderly need' betray a blanket assumption about who people are. People are different, as our values segmentation showed – as such we need to learn how to vary our interventions and services to get optimum results.
Medicalization of care	As care and health services integrate, it is entirely possible we over medicalise issues which have a more social solution. This will financially cost us dear.
Preventative dysfunction	Local preventive services and interventions are poorly joined up. We might be concerned with behaviours that emphasis care and treatment over prevention and early help. We risk creating a gold standard service for failure demand whilst neglecting more powerful system-wide preventive coordination
Information poverty	Via Home Truths we have been struck by behaviours which limit information flows across professional groups. And equally concerned not enough professionals have the 'DNA' to share information across other professions. Even simple service signposting is poorly executed

Patient/ User behaviours

Family and Friend Influence	Our research suggests this is a huge factor in driving access. Older people rely heavily on the advice of their children. But often their children lack the basic information they need
Professional submissiveness	We know many people are significantly predisposed to deference and surface satisfaction with health professionals and institutions in particular. For these people, we need to engage differently. Figuring out what they really want and need from integrated care will be harder.
Isolation	Isolation is sometimes referred to as if it is a disease or condition. In fact it is often a behavioural issue that requires a behavioural and social intervention. It cannot be resolved with the traditional tools of the NHS and care services. Isolation is such a significant health risk factor.
Gaming	A key segment of patients now feel they have to 'game' the system, resulting in real cost pressures and issues of fairness and equity.

Both patient/user and professional behaviours

Risk Aversion	Risk aversion is a significant driver of behaviour across all of the segments. Greater communication is an important aspect in dealing with this but it is more complex than basic 'information sharing' can address. Tackling risk aversion will require us to move towards models of co-production with fellow professionals, patients and families. Shared ownership of the care journey will help patients feel more in control of their own care and also help professionals to decide, collaboratively, the best course of action
Inappropriate access	Access at the 'wrong' points, typically A&E is a major demand side issue. But it is also fed and reinforced by the supply side, via some GPs and residential care.
Engagement	Social care and the NHS, at times, develop excellent relationships, coproduce, consult and engage. National Voices is a great example of how the sectors are moving forward. But high engagement performance is not the norm. Too often a pastiche of engagement is delivered, without serious reference to behavioural economics or segmentation. We have a lot to learn and a long way to go.
Entitlement and co-dependency	Every unit of public service has a cost and benefit, even when it is free at the point of delivery. Yet in the transaction between the patient/user and care and health services we often behave as if one party has an entitlement and the other fulfils that entitlement. The most powerful behaviour changes we have delivered, e.g. in Fostering and Special Education Needs, have explicitly challenged lazy notions of entitlement.

Integrating care: Can we succeed?

This report has a single function; to highlight the importance of behaviours, attitudes and motivations alongside structures and systems as we integrate care.

We are clear this is a big and complex challenge with a high degree of difficulty. Internationally, there is not an analogous, successful example in another territory (albeit we can take learning from a range of non-analagous systems).

We are also clear that without a behaviourally guided approach health and care economies are liable to fail in the challenge of integration. This sounds dramatic but it is, in fact, prosaic. Our health and care services are not production lines or mechanical devices. They are, at their best, a series of intelligent human responses to widely different human contexts. Focusing on behaviours in the context of this challenge is merely addressing what we all really know – that when people have to provide help to people, how both sides behave is the crux of whether it does good or ill.

"They think if you're eighty five all they need to do is treat your illness and then leave you sitting there, we need more…" **Focus Group Participant[38]**

38 Focus group

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