Key principles when gathering Behavioural Insights

11am-12pm, Thursday 29th June 2023, Online

Academic Health Science Network
North East and North Cumbria

NIHR | Applied Research Collaboration North East and North Cumbria

Welcome

Professor Eileen Kaner

Director of the NIHR Applied Research Collaboration (ARC) for the North East and North Cumbria

Professor Julia Newton

Medical Director, AHSN NENC

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- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required.
- The event is being recorded and will be shared.
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- If you cannot see the chat, please email your question/s to sarah.black@ahsn-nenc.org.uk
- Speaker presentations and the recording will be circulated following the event.

Agenda

11:00 **Welcome,** Chair
Professor Eileen Kaner, Director, NIHR Applied Research Collaboration (ARC) for the North East and North Cumbria
Professor Julia Newton, Medical Director, AHSN NENC
11:05 **What is Behavioural Insights and the EAST Framework**
Dr Hayley Alderson, Senior Research Fellow, Children and Families theme, NIHR Applied Research Collaboration (ARC) North East and North Cumbria
Liam Spencer, Research Assistant, Newcastle University and Mental Health Fellow, NIHR Applied Research Collaboration (ARC) for the North East and North Cumbria
11:15 **Using Behavioural Insights to Improve the Uptake of Services for Drug and Alcohol Misuse**
Hartlepool Borough Council
11:35 **Q&A**
11:40 **NENC Innovation in Healthcare Inequalities Programme (InHIP)**
Dr Joe Chidanyika, National AAC/AHSN Lipid and FH Programme Manager, AHSN NENC
11:50 **Summary and close**
Professor Julia Newton, Medical Director, AHSN NENC
12:00 **Close**

What is Behavioural Insights and the EAST Framework

Dr Hayley Alderson

Senior Research Fellow, Children and Families theme, NIHR Applied Research Collaboration (ARC) North East and North Cumbria

Liam Spencer

Research Assistant, Newcastle University
Mental Health Fellow, NIHR Applied Research Collaboration (ARC) for the North East and North Cumbria

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Behavioural Insights

Hayley Alderson and Liam Spencer

NIHR Applied Research Collaboration (ARC) North East and North Cumbria (NENC)

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What are Behavioural Insights?

- Behavioural Insights have been used across public services to generate low cost interventions to improve service outcomes.
- Behavioural Insights encourage people to make better choices for themselves and society.
- Resources and examples can be found on the Behavioural Insights Team and the Local Government Association websites:

  https://www.bi.team/

  https://www.local.gov.uk/our-support/behavioural-insights

The EAST framework

- The EAST framework was developed by the Behavioural Insights Team from early 2012.
- If you want to encourage a behaviour, make it **Easy**, **Attractive**, **Social** and **Timely** (EAST).
- EAST should lead to services that are easier and more pleasant for citizens to use, and more effective and cheaper too.

Principle 1: Make it Easy

- Harness the power of defaults. We have a strong tendency to go with the default or pre-set option, since it is easy to do so. Making an option the default makes it more likely to be adopted.
- Reduce the ‘hassle factor’ of taking up a service. The effort required to perform an action often puts people off. Reducing the effort required can increase uptake or response rates.
- Simplify messages. Making the message clear often results in a significant increase in response rates to communications. In particular, it’s useful to identify how a complex goal can be broken down into simpler, easier actions.

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Principle 2: Make it Attractive

- Attract attention: We are more likely to do something that our attention is drawn towards. Ways of doing this include the use of images, colour or personalisation.

- Design rewards and sanctions for maximum effect: Financial incentives are often highly effective, but alternative incentive designs (such as lotteries) also work well and often cost less.

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Principle 3: Make it Social

- Show that most people perform the desired behaviour. Describing what most people do in a particular situation encourages others to do the same. Similarly, policy makers should be wary of inadvertently reinforcing a problematic behaviour by emphasising its high prevalence.
- Use the power of networks. We are embedded in a network of social relationships, and those we come into contact with shape our actions. Governments can foster networks to enable collective action, provide mutual support, and encourage behaviours to spread peer-to-peer.
- Encourage people to make a commitment to others. We often use commitment devices to voluntarily ‘lock ourselves’ into doing something in advance. The social nature of these commitments is often crucial.

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Principle 4: Make it Timely

- Prompt people when they are likely to be most receptive. The same offer made at different times can have drastically different levels of success. Behaviour is generally easier to change when habits are already disrupted, such as around major life events.
- Consider the immediate costs and benefits. We are more influenced by costs and benefits that take effect immediately than those delivered later. Policy makers should consider whether the immediate costs or benefits can be adjusted (even slightly), given that they are so influential.
- Help people plan their response to events. There is a substantial gap between intentions and actual behaviour. A proven solution is to prompt people to identify the barriers to action, and develop a specific plan to address them.

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Understanding the problem: 4 steps

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Case Study: Hartlepool Action Recovery Team (HART)

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1. Define the outcome

- Hartlepool has the second highest rate of deaths from drug misuse in the North East of England and the seventh highest nationally (John, Butt and McQuade, 2019).

- The research team worked with Hartlepool Borough Council staff to define the primary outcome, which was to increase treatment uptake. We also established that the method of measuring this outcome would be to use routinely-collected NDTMS data.

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2. Understand the context

The project aimed to answer the following question:

"What factors influence the decision to take up or decline treatment offer?"

- To understand the issue and context regarding what factors influence the decision to take up or decline treatment offer, we conducted (1) a survey and (2) qualitative interviews.

- A researcher was also embedded at the site to observe practice.

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Data collection and the EAST framework

EAST Framework Component	Description	Factors assessed in survey
Easy	Ease of attending the service for appointments and assessments.	Cost and time required to travel to and from appointments The amount of time and effort taken up by appointments and how these fit around other commitments. Understanding of what treatment would involve. Usefulness of appointment reminders.
Attractive	How appealing treatment is.	Perceived benefit of treatment Perceived protection of confidentiality and privacy. Emotional response to treatment centre (e.g. feeling relaxed/on edge)
Social	Positive or negative views of other service users and treatment centre staff. Perceived support for treatment involvement from friends and family.	Family/friends awareness and support Perception of others receiving treatment Perception of treatment centre staff
Timely	Indications of whether the respondent is ready to change their substance use. How long they have to wait for/between appointments.	Wait time for initial appointment Wait time between appointments. Motivation to change.

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Findings

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Survey Participants

- *n*=53 responses were received
- $^{2}/_{3}$ of respondents were male (*n*=35 Male; *n*=18 female)
- Participants were aged between 22 and 64 years (Mean = 40.5 years)
- The majority of respondents were unemployed (79%), *n*=5 were in full-time or part-time employment, and *n*=2 were in part-time education.
- The majority were single (81.1%) with *n*=3 being married, *n*=3 co-habiting and *n*=3 in a relationship.

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Qualitative Interview Participants

- *n*=15 participants were interviewed
- The majority of participants were male (*n*=11).
- All participants were aged 18 years and over
- Participants reported using heroin, alcohol, cannabis, cocaine, and amphetamines, as well as misuse of prescription drugs
- All participants were White British, in keeping with the local demographic
- Interviews lasted 10 -50 min (Mean = 30 min)

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1. Ease of Attending Appointments

- Over all ease of attending appointments was acceptable and the majority of respondents (60%) identified that appointments fit around the rest of their lives.
- Approximately 20% of respondents did not find it easy to get to and from appointments and a similar number reported that this could be expensive.
- 72% felt it would be useful to receive text-message reminders the day before appointment
- 50% agreed that it would be useful to receive appointment letters.

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1. Ease of Attending Appointments

"No reminders or anything like that. You know, if they give you an appointment card for a month's time, how the fuck are you going to remember that?" (Service User 12, Male)

"If people are coming from over the other side of town, in bad weather, [only] to find that there's just a note on the door to say that the meeting is not going ahead, it's not very good, is it?" (Service User 6, Female)

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2. Attractiveness of Treatment

- 32% of respondents would have liked more information about what to expect from treatment.
- Whilst 80% of respondents identified that they were made to feel welcome a quarter of respondents reported feeling ‘on edge’ at the treatment centre.
- Almost half of respondents agreed with the statement that they would be more likely to attend if they knew how much appointments cost to provide.

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2. Attractiveness of Treatment

"I didn't like going there anyway because of how it looked outside when people are under the influence [of drugs] outside. I didn't want to be tarred with that brush." (Service User 6, Female)

"Because of my knowledge, and the amount of time I've been in services, I do tend to find them quite tedious and boring in all honesty. It's nothing to do with the staff or the content, it's because I know it all and it's a bit like sucking eggs." (Service User 11, Male)

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3. Social Aspect of Treatment

- Respondents generally perceived themselves to have a lot in common with others receiving treatment and held positive perceptions of those in treatment.
- Perceptions of treatment centre staff were also positive though staff were less likely to be rated non-judgemental than as friendly, respectful and easy to talk to.
- Three quarters of respondents had family who were aware that they had been referred to treatment and supportive of this while over half had friends who were aware and supportive.
- However, a third of respondents identified substance use as a part of their identity and over half stated that it was a big part of their life, factors which may inhibit their ability to change their substance use behaviour.

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3. Social Aspect of Treatment

"My neighbour next door, he comes here as well. He's been clean the same time. We've, sort of, helped each other. He copes, I cope." (Service User 14, Male)

"You have people who don't need that trigger. They don't need to come into a building and see people who are a little bit further back in their recovery." (Service User 4, Female)

4. Timeliness of Treatment

- Overall, the waiting time for an initial appointment and between subsequent appointments was generally seen as acceptable.
- Over a third of participants reported that they had to wait a long time for their first appointment.
- Almost 20% of participants reported that they had to wait a long time between appointments.

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4. Timeliness of Treatment

“He’s usually quite quick when it comes to responding to texts or calls, it’s just actually trying to get an appointment that’s the problem.” (Service User 3, Male)

"They actually had a cancellation or something, so they were able to see me more or less straight away, which was helpful.” (Service User 9, Male)

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3. Build your intervention

Following data collection, we triangulated our findings and held a co-production workshop with *n*=17 HART staff members:

- This began with a summary of findings from the behavioural insights survey, qualitative interviews and research assistant observations.
- Staff had the opportunity to offer any additional comments or experiences about approaches and strategies that have or have not worked in the past.
- The second half of the workshop involved the presentation of the proposed redesign. Staff then had the opportunity to contribute to the design process by offering any comments, suggestions or changes.
- This led to the production of recommendations and nudges.

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Recommendations

Recommendation 1: Systematically provide an appointment card for EVERY appointment and send automated text reminders the day before the scheduled appointment.

Recommendation 2: Having a duty worker available and/or fitting in service users to other groups/counsellors was preferred rather than cancelling sessions and may increase retention. Have a ‘best practice’ guideline to assess all newly-presenting service users within 2 working days of referral.

Recommendation 3: Calculate the cost of each missed appointment and display it clearly within the treatment agency premises for service users to see.

Recommendation 4: ALL staff need to use motivational interviewing skills to pro-actively promote that service users in receipt of a script start to engage with psychosocial interventions available within the service.

Recommendation 5: Raise the profile of service.

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Recommendations

Recommendation 6: Display the timetable/provide ALL service users with details of the whole service offer (including groups etc.) and provide a clear expectation of what treatment will entail.

Recommendation 7: While finding alternative premises is likely to be costly and therefore unfeasible, some visible investment should be considered to improve safety of staff, volunteers and service users. Improving the feel of the building, by making cosmetic changes to the interior, such as improving the room for mindfulness, would also improve the experience of service users. A review of the space usage and/or the size of groups should also be considered.

Recommendation 8: Assess whether it is practical and helpful to stream service users according to their stage of recovery and examine the effect of this on retention.

Recommendation 9: Consider running separate sessions for those treated for alcohol and drug use.

Recommendation 10: Extend the opening hours of the service.

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Nudges

Behavioural Insight Nudges:

We are aware that service users failing to turn up for their appointments has a direct impact on services; methods need to be used to increase retention rates.

- Nudge 1 (Recommendation 1) Appointment cards: Systematically provide an appointment card for every appointment and send automated text reminders the day before the scheduled appointment. Cards need to include the following information:

Next appointment:	
Date:	Time:
Practitioner name:	Location:

- Nudge 2 (Recommendation 1) Text reminders - All practitioners to use the same (automated) text and use consistent wording in all messages sent to service users.

> We are expecting you at (location) on (day, date and time).
> Not attending costs HART approx. £2,960 last month.
> Please call HART on xxxx if you need to cancel or rearrange.

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Nudges

- Nudge 3 (Recommendation 3) Display the cost of missed appointments - Calculate the cost of each missed appointment and display it clearly within the treatment agency.

  There was a total of 251 missed appointments in December 2019, @ £11.79 per half hour appointment with a total loss to the service of £2,960.14. This would be displayed as follows:

In December 2019
There were 251 missed appointments.
Not attending costs HART £2,960.14
Please let us know if you need to cancel or rearrange.

- Nudge 4 (Recommendation 6) Display the timetable of service offer and use Motivational Interviewing skills to engage service users in Psychosocial Interventions (Recommendation 4)- provide ALL service users with details of the whole service offer (including groups etc.) and provide a clear expectation of what treatment will entail.

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4. Test, learn, adapt

- The recommendations and nudges were rolled out from September 2019.
- A full service redesign was scheduled in June 2020.
- The service leads were mindful to use the NDTMS data, pre- and post- the introduction of recommendations to provide a baseline for service improvements, and to establish whether further changes are required.

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Any Questions?

NENC Innovation in Healthcare Inequalities Programme (InHIP)

Dr Joe Chidanyika

National AAC/AHSN Lipid and FH Programme Manager, AHSN NENC

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Public health background & Research interests

- Cardiothoracic surgical experience – **extreme end of CVD interventions**
- Over 17 years Public Health **commissioning and health improvement involvement**
- **Population Health Management** at Primary Care Trust / Local Authority Public Health regional leadership
- Behavioural Insight Community Development initiatives for **suicide prevention** and **self-harm** in Teesside
- Behavioural Insight research for Middlesbrough's transient asylum seekers / refugee communities for **communicable diseases** – TB / STIs
- At scale commissioning of mandated services including **NHS Health Checks** and **sexual health integrated services** within Teesside
- AHSN **Patient and Public Involvement insights** around lipid optimisation approaches at a national level
- Thesis focused on a **phenological exploration** of mental health service users' lived experiences (Behavioural Insights) of how disparities in CVD optimisation treatment affects life expectancy and quality of life
- Academic scholarly at Teesside University spanned **18-year academic years** from pre to postgraduate

The InHIP NENC Research Team

Prof Julia Newtown	(AHSN NENC)
Dr Joe Chidanyika	(AHSN NENC)
Karen Verrill	(AHSN NENC)
Emma Reynolds	(AHSN NENC)
Ben Porter	(AHSN NENC)
Prof Eileen Kaner	(ARC)
Prof Steph Scott	(ARC)
Jen Portice	(ARC)
Sophia Brady	(ARC)
Sarah Slater	(Middlesbrough Public Health)
Katrina Jackson	(Middlesbrough Public Health)
Idrees Rashid	(Middlesbrough Public Health)

Innovation for Healthcare Inequalities Programme

Aims:

- **To address local healthcare inequalities** experienced by deprived and other under-served populations
- For AHSNs to work together with our local communities **(co-designing)** to identify, address and minimise healthcare inequalities through projects that improve access to the latest health technologies and medicines.
- For health technologies and medicines to focus on **five clinical areas of priority** that closely align with the **national Core20PLUS5**
- Nationally a total of **£4.2 million** was made available
- NENC InHIP project – "**Co-designed approach to Cardiovascular Disease Prevention in Middlesbrough",** funded for **£100k – (collaboration between NENC ICB, AHSN NENC, Middlesbrough Public Health, Newcastle University – ARC)**

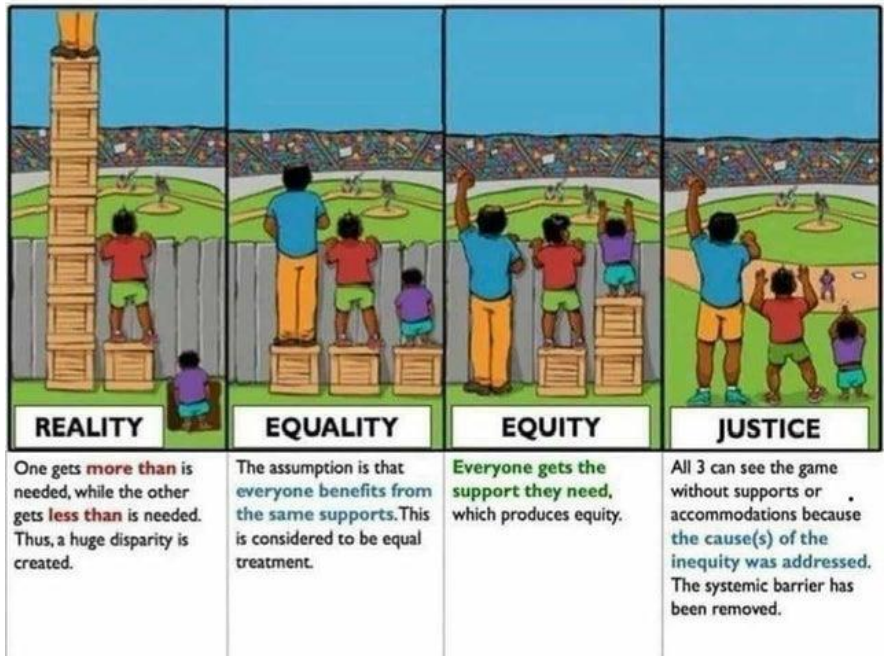
Context for InHIP

- The AHSN Network and Accelerated Access Collaborative have worked together over the last 5 years to **support the national spread and adoption of product-based medicines and medical technologies with NICE guidance**

- This work has focused on the general population, most of whom readily access NHS services, **yet our approaches have not always enabled access for most under served groups**, and particularly those populations described in the Core20PLUS5 approach

- A new AAC-AHSN Network innovation programme will focus on healthcare inequalities using the Core20Plus5 approach – the **Innovation for Healthcare Inequalities Programme** (InHIP)

- Each AHSN will **support ICSs to scale product-based innovations**, aligned with the Core20Plus5 approach and local ICS priorities



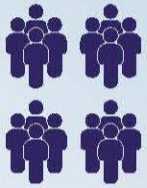
REDUCING HEALTHCARE INEQUALITIES

NHS

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups



Target population

CORE20PLUS5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensure annual Physical Health Checks for people with SMI to at least, nationally set targets

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

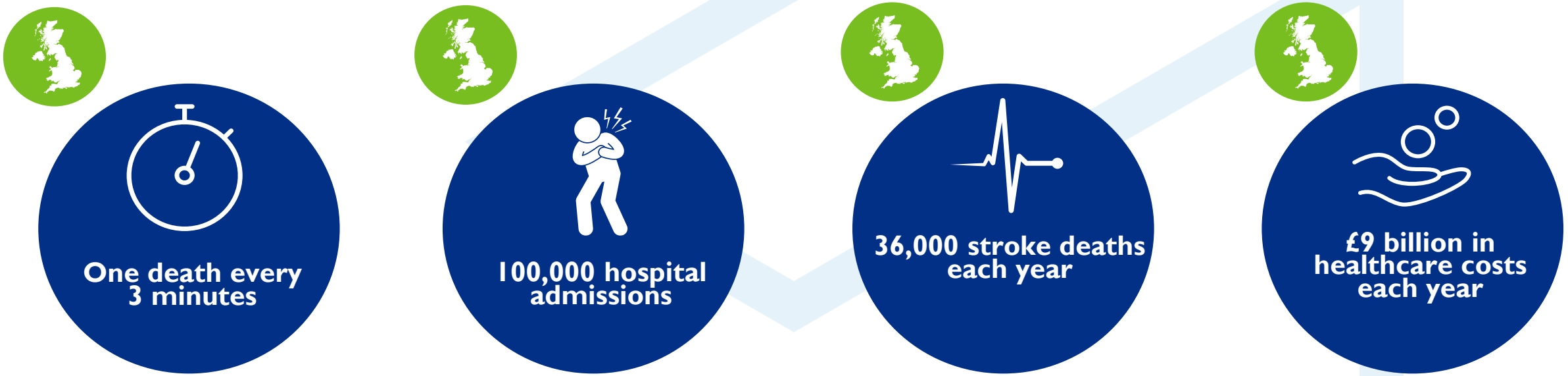
4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

The Scale of The Challenge: Cardiovascular disease (CVD) is a leading cause of death in the UK

85% of all CVD deaths are due to heart attack or strokes



27% of all UK deaths are due to CVD

1 death every

100,000 heart attack hospital admissions/year

1 admission every 5 minutes

Stroke is the fourth biggest killer in the UK

100,000 admissions each year

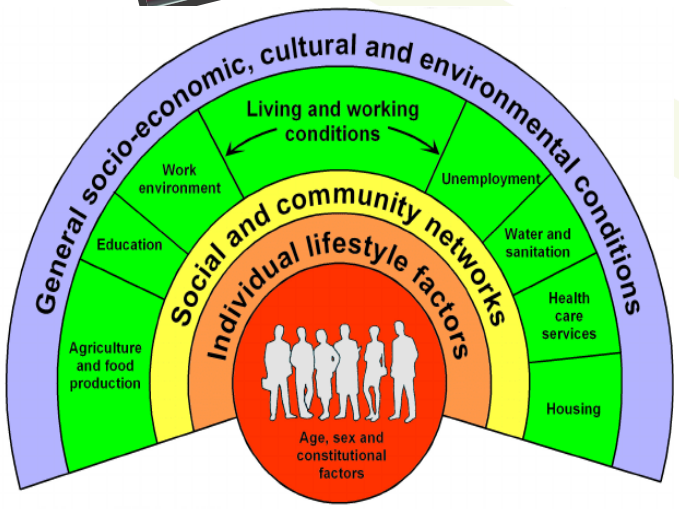
Overall CVD costs the UK economy ~

£19 billion each year

Examples where BI have been Used In Public Health

Behavioural Science Insights have been applied within health settings to affect behaviour:

1. **Smoking cessation services**: - smokers perception of incentives to quit and their commitment
2. **Organ donation**: - what makes people opt in/out to increase donor numbers
3. **Teenage pregnancy**: - understanding how **teenagers who mentor** toddlers are significantly less likely to become teen parents themselves
4. **Alcohol and drug misuse**: - using social norms to influence addiction issues. Did you know it takes at least 28 days to kick a habit?
5. **Diet and Weight**: - how can public health commissioned services encourage healthy lifestyle? Copy customer behavioural insights of big marketing corporations? Why do I get pizza coupons junk mail adverts on my doorstep or email inbox ☺!!!
6. **Food hygiene**: - educating people about the National Food Hygiene Rating Scheme to avoid unscrupulous restaurants and **reduce food poisoning**
7. **Physical activity**: - Step2Get' initiative in London, **Couch to 5K** – FitMind
8. **Suicide prevention**: what are protective factors for children and young people and men who are vulnerable to suicide ideation?
9. **Knife crime**: - **what drives young people** to gangs and violence?



Source: Dahlgren and Whitehead, 1991

What we are doing – working with communities through BIs?

- Raise awareness of what CVD is, what it causes and the simple steps that can be taken to help prevent it
- Understand the needs of different groups of people in Middlesbrough
- Make it easy for everyone to have a check for their risk of CVD including BP and cholesterol checks at home or in a pharmacy if they prefer – increased accessibility

What we hope to achieve

Work with communities in Middlesbrough

- Use the **EAST Framework** to attain **Behavioral Insights** of our target participants
- Raise awareness
- Reduce risk
- Understand why some groups in Middlesbrough don't engage with Annual health checks aimed at reducing CVD
- Reduce hospital admissions / stays
- Save lives

EAST Framework Themes From Focus Groups To Date

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www.ahsn-nenc.org.uk
@AHSN_NENC

What are the Perceived Challenges applying B.I.?

VCSE Community Champions / participants **engagement**, capacity to engage and availability **(Achieved)**

IG and data sharing across parts of the system **(In Progress)**

Communication and **engagement** with ICB /ICS delivery teams **(Achieved)**

ICS **workforce capacity,** current pressures on the NHS are impacting the capacity of teams to deliver on the project **(Key Concern)**

Engagement with PCNs **(In Progress)**

Engagement with target populations and attendance at community outreach events (Focus Groups / Behavioural Insights) **(In Progress)**

Lack of clarity on **governance** structures and leadership. Routes for escalation and decision making and ownership of the project isn't clear **(Achieved)**

Contact Details

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Summary and Close

Professor Julia Newton

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