“It’s difficult, I think it’s complicated”: Barriers and enablers to health professionals providing opportunistic behaviour change advice

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Background

- Health professionals are an expected and trusted source of behaviour change advice.
- Opportunities to support behaviour change are often missed – Time, workload, role responsibility.
- “Making Every Contact Count” – Concise, opportunistic health behaviour change interventions – Encourage behaviour change, direct patients to local services.
- Opportunistic behaviour change advice could be given further priority – Weight loss\(^3\), identifying important health risk factors\(^4\).

“MECC Level 1: Very brief intervention – a very brief intervention can take from 30 seconds to a couple of minutes. It enables the delivery of information to people, or signposting them to sources of further help. It may also include other activities such as raising awareness of risks, or providing encouragement and support for change.”

\(^1\)Elwell et al. (2013) \(^2\)Nelson et al. (2016) \(^3\)Aveyard et al. (2016) \(^4\)Gulliford et al. (2017)
Aim

- To examine cross-disciplinary barriers and enablers to delivering opportunistic behaviour change advice
Methods

- **Design:**
  - Semi-structured interviews with patient-facing health professionals
- **Sample:**
  - All health professionals were invited (NHS, patient-facing)
  - Participants had previously taken part in a large cross-sectional survey
- **Procedure:**
  - Topic guide informed by COM-B (capability, opportunity, motivation)\(^5\)
  - Open-ended questions encouraged participants to explore their professional practice
  - Specific instances and occurrences (where and when)
  - Interviews audio recorded and transcribed

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\(^{5}\)Michie et al. (2014)
Analysis

- Theoretical Domains Framework
  - **Environmental** (e.g. resources), **social** (e.g. interpersonal influences), **cognitive** (e.g. decision processes), and **affective influences** (e.g. optimism) on health professional behaviour (i.e. delivering opportunistic behaviour change interventions)\(^6\)

- Framework approach to map data to theoretical domains

- First level (deductive) coding to generate coding framework; second level (inductive) to generate themes in line with TDF

\(^6\)Atkins et al. (2017)
<table>
<thead>
<tr>
<th>TDF Domain</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>An awareness of the existence of something</td>
</tr>
<tr>
<td>Skills</td>
<td>An ability or proficiency acquired through practice</td>
</tr>
<tr>
<td>Social/Professional Role and Identity</td>
<td>A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting</td>
</tr>
<tr>
<td>Beliefs about Capabilities</td>
<td>Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use</td>
</tr>
<tr>
<td>Optimism</td>
<td>The confidence that things will happen for the best or that desired goals will be attained</td>
</tr>
<tr>
<td>Beliefs about Consequences</td>
<td>Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation</td>
</tr>
<tr>
<td>Reinforcement</td>
<td>Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus</td>
</tr>
<tr>
<td>Intentions</td>
<td>A conscious decision to perform a behaviour or a resolve to act in a certain way</td>
</tr>
<tr>
<td>Goals</td>
<td>Mental representations of outcomes or end states that an individual wants to achieve</td>
</tr>
<tr>
<td>Memory, Attention and Decision Processes</td>
<td>The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives</td>
</tr>
<tr>
<td>Environmental Context and Resources</td>
<td>Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour</td>
</tr>
<tr>
<td>Social Influences</td>
<td>Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours</td>
</tr>
<tr>
<td>Emotion</td>
<td>A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event</td>
</tr>
<tr>
<td>Behavioural Regulation</td>
<td>Anything aimed at managing or changing objectively observed or measured actions</td>
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**COM-B domains mapped to the TDF Domains**  
Michie et al. (2014)

<table>
<thead>
<tr>
<th>COM-B Domain</th>
<th>TDF Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical capability</strong></td>
<td>Physical skills</td>
</tr>
</tbody>
</table>
| Having the physical skill, strength or stamina to engage in the activity concerned.  
(e.g. I have sufficient physical stamina, I can overcome disability, I have sufficient physical skills) | Knowledge; Cognitive and interpersonal skills; Memory, attention and decision processes; Behavioural regulation |
| **Psychological capability**              |                                                 |
| Knowledge and/or psychological skills, strength or stamina to engage in the necessary thought processes for the activity concerned.  
(e.g. having the knowledge, cognitive and interpersonal skills, having the ability to engage in appropriate memory, attention and decision making processes.) | Professional / social role and identity; Beliefs about capabilities; Optimism; Beliefs about consequences; Intentions, Goals |
| **Reflective motivation**                  |                                                 |
| Conscious planning and evaluations (beliefs about what is good and bad)  
(e.g. I have the desire to, I feel the need to) | Reinforcement; Emotion |
| **Automatic motivation**                   |                                                 |
| Automatic motivation involves doing something without thinking or having to consciously remember  
(e.g. ‘is something I do before I realise I’m doing it’) |                                                 |
| **Physical opportunity**                  |                                                 |
| The environment provides the opportunity to engage in the activity concerned.  
(e.g., sufficient time, the necessary materials, reminders) | Environmental context and resources |
| **Social opportunity**                    |                                                 |
| Interpersonal influences, social cues and cultural norms provide the opportunity to engage in the activity concerned  
(e.g., other colleagues engaging in the activity, support from managers) | Social influences |
### Results

- **Participants:**
  - All health professionals were patient-facing working in the NHS
  - Predominantly female (n=24; 86%) and White British (n=26; 93%)
  - Interviews 22m to 42m, mean length 30m
  - Age (range=28-67 years; mean=48 years)
  - Setting: Acute (n=13; 46%); Tertiary (n=1; 4%); Community (n=8; 25%); Primary (n=6; 21%)

#### Health Professional group

<table>
<thead>
<tr>
<th>Professional</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>Nurse (mental health)</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>Nurse (dermatology)</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>GP</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>Midwife</td>
<td>3 (11%)</td>
</tr>
<tr>
<td>Audiologist</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Health visitor</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Mental health worker</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Anaesthetist</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Dentist</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>
Results

Cross-disciplinary TDF domains

Beliefs about consequences

Beliefs about capabilities

Social / professional role and identity

Environmental context and resources
1. Beliefs about consequences

Health professionals recognised the importance of opportunistic behaviour change advice. However they believed it was often inappropriate in the context of an existing medical problem. Consequently patients may respond negatively and disregard the information.

“They get annoyed with you because you’ve brought it up and they don’t see it as being relevant to the consultation that they’re having.’ (24516, GP)

“They will think, oh well, the midwife didn’t say anything about me smoking; or the midwife didn’t say anything about me being massively overweight or whatever, so it must be okay.’ (21547, Midwife)

Health professionals consciously decided which patients to engage with in conversations (depending on how they thought patients would respond). Could lead to false reassurances and damage health professional-patient relationship.
2. Beliefs about capabilities

Health professionals perceived a lack of confidence to have conversations that focused on long-term planning of behaviour change. They also believed an inability to convey information in a meaningful way, that has an impact on patients’ health behaviours.

‘There's perhaps a lack of awareness as to how to go about it, or that you can make the difference. And with that, a feeling that, well, if other people have this role, they must be able to do it a lot better than I, I'll pass it on to them to do properly, as it were, rather than me have a half-hearted bash at it.’ (23404, GP)

Health professionals felt restricted by their specialist role, and believed that behaviour change advice fell outside of their professional remit. The main focus was to address the primary medical complaint (unless it was directly related to the topic of discussion).

‘We don’t talk about anything else, you know, like obesity or anything like that, or healthy eating. We just do it about smoking, because I guess we felt we had a good reason to ask about smoking.’ (1552, Audiologist)
3. Social / professional role and identity

Health professionals emphasised the importance of being an advocate for healthy lifestyle. Patients observing health professionals engage in unhealthy lifestyle was perceived as having a detrimental effect on the credibility of information.

‘It’s frustrating for example when staff members are smoking and the policies of no smoking at work aren’t enforced and that’s difficult, because then you feel like you’re working against, you’re telling patients one thing but then the staff are role modelling another behaviour.’  
(21546, GP)

‘The midwife’s role of advocacy is very, very important. It’s part of, you know, the main moulding of being a midwife and caring for omen in pregnancy to, kind of, be able to encourage women to be empowered.’  
(21551, Midwife)

Health professionals reported that only certain aspects of behaviour change were discussed in their relative specialisms. Some health professionals stated that frequent one-to-one contact facilitated discussions, and provided the opportunity to support and encourage patients.
4. Environmental context and resources

Competing demands such as completing a number of clinical tasks (biomedical measurement, diagnosis, formulating a management plan, discharging patients) restricted opportunities for behaviour change intervention. Psychological demands created low morale and lack of engagement.

‘There’s a little bit of demotivation, I would say, in the NHS at the moment. And this is extra. I mean we may not…Maybe it shouldn’t be extra but it is an extra role, an extra job.’ (23663, Anaesthetist)

‘I really need some kind of centralised database of information of what’s about there that’s held on the intranet or something like that so that any member of staff could just go and access that easily.’ (247, Physiotherapist)

Across all professions, the need to have an environment that facilitated private discussions about behaviour change was highlighted as opposed to a busy clinical environment. Additionally professionals highlighted the need for better awareness of services to signpost patients to.
Discussion

• **Environment must be conducive** to having discussions about behaviour change; resources, signposting (*Environmental context and resources*)

• Advice based on ‘need’ rather than judgments of patient ‘responsiveness’ (*Beliefs about consequences*)

• **Continuity of care** seen as important in support long-term behaviour change (*Social/professional role and identity*)

• **Widen the scope of the consultation** to consider patients in a broader way (*Beliefs about capabilities*)
  – Beyond the biomedical model; Prevention and management
Strengths and limitations

• A range of views spanning different medical professions with varying priorities and opinions

• Must also be considered in light of the most commonly reported NHS-specific barriers
  – Time / Workload pressures, morale

• Using other analytical approaches may have generated more spontaneous thematic findings, not explained by the TDF.
Implications and Conclusions

• Health professionals see the value of opportunistic behaviour change advice

• There are common barriers and enablers across health professional disciplines

• Possible to make NHS-wide recommendations for delivery of opportunistic behaviour change advice
Thank you

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