Using Behaviour Change to Improve Value

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Why a Behaviour Change approach?

Behavioural science is about choice-making –

Why do people make the decisions that they do?
How do they make them?
How do they receive and account for the information we give them?
How should we design and build these in such a way that more people choose to do what the evidence says we should?

If we account for how the mind works, we increase the rate of good choices and decisions (our own and those of others – our workforce and the population).

Using a Behaviour Change approach is NOT about restarting/ redesigning current effort. It is about complimenting what you're already doing via -

Increased use of, e.g. clinical insight, to create the best Improving Value solutions
Enhanced uptake by helping to make solutions more compelling and simpler to adopt
Ensuring the development of ideas into actual delivery, using clinical engagement

What our minds do and don’t do…

To help us navigate through life, our minds have evolved to make very quick, intuitive choices (Fast Thinking)

Sometimes this is very useful, e.g. survival instinct

Sometimes it isn’t…

- Intuitive decision-making doesn’t allow for consideration
- And that often means key information and evidence isn’t accounted for

Ambiguity Bias - An unambiguous statement

Anne approaches the bank

When you show this statement to a group of people, and ask them to picture the scene, the vast majority will picture a woman approaching a high street bank.

When asked what she is approaching the bank to do, the vast majority of these will say Anne is depositing or withdrawing money.

There is no evidence to support this – the fast thinking part of our brain has utilised Availability Bias and just assumed it, and then convinced itself that this is a robust assumption.

Similar assumptions, without evidence, are reached in work scenarios containing ambiguity. And most work scenarios are steeped in this ambiguity.

Ambiguity

With balaclava on head and gun in hand,
Anne approaches the bank

When you then show this statement to a group of people, the vast majority will amend the reason for Anne approaching the bank to be that she intends to rob it.

There is no evidence to support that it is a high street bank that she is approaching and, despite the fact that people are now able to see that they have made wrong assumptions when shown the initial statement, they will not learn from this experience by not assuming Anne is robbing the bank.

In work scenarios, it is not enough to provide partial evidence if we wish people to make safe assumptions, leading to safe and evidence-based choices and decisions, such as what to do and/ or to adopt what the national policy, guidance or pathway is trying to encourage them to do.

Most people are not aware when they are only providing partial evidence.

Ambiguity

Seeing the ducks on the river,

With balaclava on head and gun in hand,

Anne approaches the bank

When you show this statement, people finally understand that Anne is hunting ducks.
In work scenarios, if we do not provide all of the evidence, people do not assume they need more information: The fast thinking part of their brain convinces them that all of the necessary evidence is there, and that their assumptions, based on the information they do have, is enough to make robust decisions.

Without accounting for this, with experts, we rarely, if ever, provide the complete information needed to stop our fast thinking from making these inaccurate assumptions, leading to inaccurate decisions on what to do next.
This is a major cause of subsequent unwarranted variation, including decisions not to adopt the evidence-based correct actions at all.

The Halo Effect

How much do you like someone?

Read this description of Alan, decide if you like him and score his character out of twenty (twenty being “a very decent bloke” and zero being “I wouldn’t wish him on my worst enemy”) –

Alan is intelligent, hard-working, inventive, challenging, obstinate, envious.

Now do the same for Ben –

Ben is jealous, stubborn, critical, creative, industrious, clever.

The vast majority of people prefer Alan to Ben

In reality, Ben and Alan have the same personality. However, just by framing the list differently (in this case, by reversing the order of the list and using a thesaurus to change the words but not the meaning), the human mind responds differently and reaches a different decision (whether to like the person or not). The same happens when making choices in the workplace, such as whether to adopt/ support a change or not.

Quick and Easy Maths

A bat and ball cost £1.10

The bat costs one pound more than the ball

How much does the ball cost?

The fast thinking part of our brain will answer this question quickly. For the majority the answer provided will be 10p. Fewer people who work regularly with numbers will make this mistake, but still the majority will. Only people who have time to ponder the question further, will realise the answer is 5p. Most will move on and never realise their mind has tricked them.

Heuristics and how accounting for them can Enhance Impact

Ambiguity Bias

Ambiguity is a significant cause of **unwarranted variation**. It is present whenever humans communicate, including in how we write guidance, letters and implementation plans. Ambiguity leads to fewer people being convinced to act, and for many who are, to misinterpret what they should do. These both lead to unwarranted variation.

*Awareness of Ambiguity Bias means we can **remove it from the design of our plans and models** and from the framing of our supporting narratives. This is **proven to increase the volume and accuracy of take up** by the frontline and the population.*

Status Quo Bias and Confirmation Bias

Status Quo Bias is an innate human preference for leaving things as they are. We intuitively look for reasons not to change. This heuristic is a proven barrier to improvement and to agendas like EDI. Confirmation Bias makes us focus on evidence that confirms our current opinion.

*Ensuring our cases for change and mobilisation packages **account for Status Quo Bias**, such as by helping people see the benefit to them from the change, improves take up and impact*

Availability Bias

The population's **perception of risk (and subsequent actions to mitigate) is driven by Availability Bias.** E.g. Media attention on accidental deaths is believed to cause the misperception held by the general public, that death by accident is 300 times more likely than death by diabetes. In reality, diabetes is at least 75% more likely to be a cause of death.

Awareness of this can be used to support, e.g. medicines optimisation and patient safety.

Denominator Neglect

Denominator Neglect makes us focus not on the actual meaning of statistics, but on the shock of the numbers used, e.g.

Disease A kills 1,286 people per 10,000
Disease B kills 24.14% of the population

Because "1,286 people" (12.86%) are more shocking than "24.14%", most people think Disease A is more dangerous.[6]

If the science proves we should encourage an action (e.g. vaccination uptake or secondary prevention) we might use the 1st denominator. If the science shows the population is overly put off something (e.g. HRT due to perceived cancer risk), we might best use the 2nd.

Heuristics are the worst culprits - Loss Aversion Bias

- **Lung cancer survival rates – surgery is significantly better than radiation in the long term, but surgery has a short-term survival risk**
    - There is a 90% survival rate at 1 month
      80+% of lung cancer surgeons recommend surgery when confronted with this statistic
    - There is a 10% risk of mortality within 1 month
      Less than 50% do when confronted with this statistic

But they are the same statistic, just framed differently!

Loss Aversion eats Expertise for breakfast!

The decisions/ choices of all humans are far more driven by avoiding losses than by achieving gains. So, e.g. the power on our minds of "lose a ward" is far greater (studies show 5x greater) than "gain a new step up/ step down facility".

Add in The Greed Gene…

System transformation and population healthcare improvement requires, amongst other things;

- Collectivism, common purpose and a financially viable system

However, use of financial language primes individualism - "The Greed Gene":

- In conversations that use the currency of money as their basis – individuals;
  - Entrench
  - Are less willing to be open-minded
  - Become less persuadable and
  - Resist the greater good.

So, talking about the need to save money is a barrier to saving money!

- Unless we change the narrative frame into clinical and population health improvement

In short – if you want to save money, don't mention the money!

Some even go so far as to write finance reports without any £ signs.

E.g. Benefits of National Menopause Programme

Aim is more women on optimal treatment pathway (e.g. experts believe 30-60% of eligible women should be on HRT. Only 10-15% are)

Will remove unwarranted variation…

- >500K GP appointments p.a. on not diagnosing menopause accurately
- 1 in 3 women wrongly prescribed anti-depressants
- Many women on the wrong pathways (Osteoporosis, Anxiety, Insomnia, Heart Disease, etc) due to poor diagnosis
- 33,000 to 50,000 female NHS workers have left their jobs when they didn't want to, due to poor menopause support and care

Will deliver…

- Reduced Outpatients
- Reduced diagnostics
- Reduced waiting lists
- Increased workforce productivity
- Improved workforce effectiveness
- Better patient care

Don't mention the money!

<<whispered>> Helping the 20% of women with severe or bothersome symptoms will save the NHS at least £500M p.a.

Why is behaviour change different?

Partly due to The Art of Not Knowing, it helps teams discover and build things that traditional approaches can't…

- **Frontline behaviour change** –
  - Cultural Norms – Nosocomial, Hugging and Making a Cup of Tea
  - Logistical barriers leading to Behavioural barriers - Wound Care Digitisation and Car Parking
- **Informed patient choices** –
  - Ambiguity, Fear of Loss and Negative Halo Effect - HRT and the NHS website
  - Common misunderstandings and Triggering Taboo Trade-Offs - Antibiotics and Children's sore throats
- **Outpatient Recovery** –
  - COM-B barriers - Awareness, Trust and Confidence
- **Population and Workforce Health Inequalities and Health and Wellbeing** –
  - Authenticity and Women's Health in NHS Wales – You can talk, but no one's listening!
- **Trust and confidence** –
  - Low COVID Vaccination uptake – It wasn't the message, it was the messenger
- **Saving money** –
  - The Greed Gene and Motivational Hooks - If you want to save money, focus on patient need and not on saving money

What happens when we think we know things we don't? Digitisation in Wound Care

No one accurately perceives what other people think. It is only by understanding the perception of the people that you need to change behaviours, that you can ever be accurate in how you support them to do so. E.g. when we asked the managers of wound care clinicians what they believed were the barriers to those clinicians adopting digital photography, they only accurately perceived 1 of the top 5 barriers that the clinicians themselves told us were the true barriers. Behaviour Change approaches ensure the true barriers are identified and tackled.

Media \ Codes	Financial	Friction Problems	Governance	Gov Consent	Gov Data Protection	Gov Technical Requirements	Key Insights	Management & Leadership	Mgt Communication	Mgt General	Mgt Training & Support	Nurse Training	Motivation	Personal Motivation	Value Based Motivation	Pathway	Assessment	Consumables	Referral	Shared Decision Making	Treatment	Patients	High Challenge Patients	Research Questions	Stakeholders	System development	Technology	Tech - Data Capture Device	Tech - Data Processing	Tech - Main System	Tech Skills	Nurse Tech Skills	Time Constraints / Stress	Travel - Time	Working Expectations - Time	Totals
WoundcareLivewellMgrs04042022.		11					7	1	1	6				17	4		2			2				1	4	5		10	2			3			8	84
Woundcare Essex Mgt Workshop	7	6	1				6		15	7	7			6	1							1					1	4	3	7	4					76
Woundcare - Hull Clinician #1.docx										1								1			1									5					5	13
NWCSP Newsletter Edition 1 April										2						1											1	1	1							6
Livewell clinician DITLO 11042022			2		1		5		1	4	4			1		8		1				1						3		3				1	4	39
Livewell Clinician 2.docx							1			6									1	1			2					1	2					1	1	16
fdgth-04-727421.pdf		1					4			1					5											6									1	18
It seems like Livewell clinician 1							1	1		3	1							1		3									1	3				1		15
220223-Digital-engagement-in-	1	3				1	1		3	6	1	4														1		3	1	1	3	2				31
Totals	8	21	3		1	1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		24	10	9	2	3	1	6	1	2	2	1	4	12	2	22	10	19	7	5		3	19	

Top 5 (all sources – clinicians' barriers):
- i) Mgt General 36
- ii) Key Insights 25
- iii) Personal Motivation 24
- iv) Tech - Data Capture Device 22
- v) Friction Problems 21

Top 5 (Managers view of clinicians' barriers):
- i) Personal Motivation 23
- ii) Friction Problems 17
- iii) Mgt Communication 16
- iv) Tech - Data Capture Device 14
- v) Mgt General 13

Top 5 (Clinicians view of clinicians' barriers):
- i) Mgt General 14
- ii) Tech - Main System 11
- iii) Working Expectations – Time 10
- iv) Pathway 8
- v) Key Insights 7

Accounting for heuristics can be simple…

The "Protect" theme, used throughout COVID:

"Protect yourself and others" was designed in the first weeks of the pandemic to nudge action across the population, building on the proven concept that human motivation to act for the community is driven by a combination of altruism (helping others) and rational egoism (helping others because it feels good, and helps yourself).

This "protect" public message theme was subsequently adopted across the world.

Or can make things simpler to increase uptake…

PRACTICAL STEPS FOR REDUCING THE RISK OF COVID-19 TRANSMISSION BETWEEN WORK AND HOME

This document outlines practical steps for healthcare staff who work in clinical areas to reduce the risk of transmitting COVID-19 from work to home.

1. LEAVING HOME

- **Clothes and shoes**
  - Consider having a separate set of designated work clothes if you do not have a uniform.
  - Consider wearing a designated pair of shoes at work.
  - Change into work clothes or uniform on arrival at work.
- **Personal items**
  - Avoid taking unnecessary items where possible (e.g. phone cases, wallet, jewellery, books).
  - Consider putting bank cards in your ID badge holder.
  - Keep your belongings in a designated non-clinical space at work (e.g. office, locker)

2. BEFORE LEAVING THE HEALTHCARE SETTING

- **Uniforms and work clothes**
  - Change out of uniform or work clothes before leaving work and take home in a disposable plastic bag.
  - For staff working in the community who often need to travel between patients, staff should cover their uniform or work clothes when travelling.
  - Uniforms should not be worn in public places, such as supermarkets or petrol stations.
- **Medical equipment (e.g. stethoscope, pen torch, diagnostic sets etc)**
  - Ensure equipment is cleaned after every patient contact and at the end of your shift using either alcohol wipes or soap and water.
- **Personal items (e.g. phone, pen, glasses, ID, wallet)**
  - Clean frequently used personal items with either alcohol wipes or soap and water before leaving work.
- **Wash hands**
  - Wash hands with soap and water or hand sanitiser after changing out of work clothes and cleaning equipment and personal items.

3. ARRIVING HOME

- **Shoes and work bag**
  - Consider having a designated space for your work clothes or uniform, shoes and work bag.
- **Wash hands**
  - Wash hands with soap and water after removing shoes, outerwear and work bag.
- **Washing uniforms and work clothes**
  - Keep unwashed uniforms and work clothes in the disposable plastic bag until they can be washed.
  - Wash uniforms and work clothes at the highest temperature suitable for the fabric as per the care label.
  - Ensure washing machine is not overloaded to maximise wash efficiency.
  - Consider tumble drying or ironing clothes once dry, as additional heat will help eradicate microbes.
  - Dispose the plastic bag which contained the uniforms or work clothes into household waste.
- **Showering**
  - There is no specific requirement to shower after returning home.

These recommendations have been developed using advice from Public Health England, NHS England and Improvement, infection prevention and control, and scientific evidence. Please use in addition to existing hand hygiene, infection control and PPE protocols.

References: Standard Infection Prevention and Control Precautions , Transmission based precautions , Uniform and workwear guidance
van Doremalen N et al. Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1. New England Journal of Medicine March 2020.

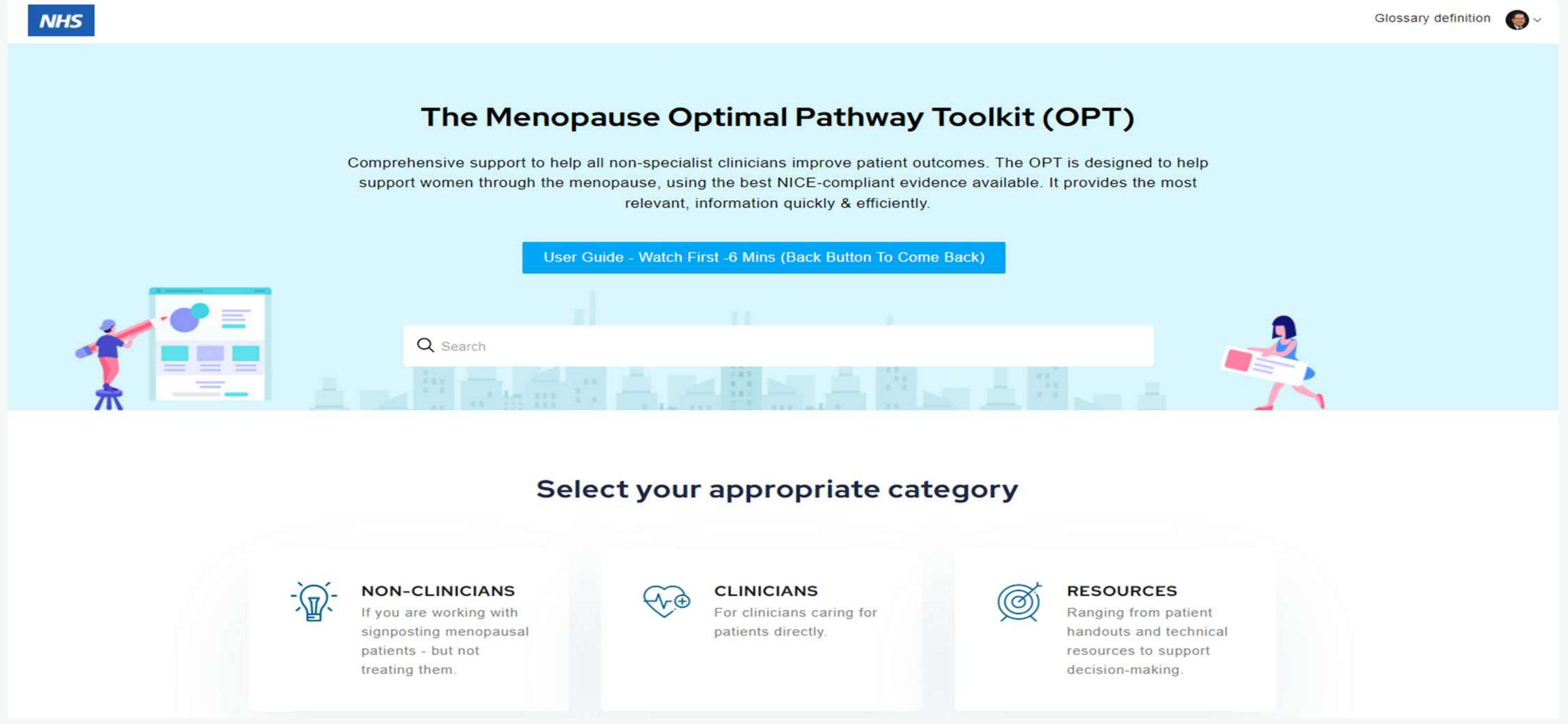
Or can be complex, but made simple to use

PERI-MENOPAUSAL & MENOPAUSAL TREATMENTS: POST DIAGNOSIS

Not every woman will want HRT. Important to consider all options through shared decision making

WHAT IS THE SYMPTOM? IRREGULAR PERIODS +	SELF CARE ADVICE	CONSIDERATIONS (can run in parallel to menopaus treatments)	WHAT ARE ALL THE FIRST LINE TREATMENT OPTIONS ?	CONSIDERATIONS (can run in parallel to menopaus treatments)	WHAT ARE ALL THE SECOND LINE TREATMENT OPTIONS?	Notes
Troublesome irregular periods (ONLY)		Heavy periods Intermenstrual bleeding Post coital bleeding Pain Consider investigation and referral and management as per NICE guidance 88	**SELF CARE** **Discuss options** Cyclical progestogens Mirena IUS	Heavy periods Intermenstrual bleeding Post coital bleeding Pain Consider investigation and referral and management as per NICE guidance 88	Consider investigation and referral Tranexemic acid / Mefenamic Acid HRT - if other menopause symptoms present Combined hormonal contraception if appropriate based on a risk asessment (UKMEC 2016)	Tranexemic acid / Mefenamic Acid for those who don't want hormonal treatment HRT not recommended for first line treatment without additional symptoms
VMS (NB diff terminology for non-medics) Hot flushes Night sweats Palpitations	*Signpost to credible self care links..* *What are these?* Avoid synthetic fabrics Fan Cold facial spray / baby wipes in freezer Refer to pharmacist for discussion re over counter options Lifestyle modifications: diet, exercise, optimising weight, alcohol, caffeine, smoking etc	Heavy periods Intermenstrual bleeding Post coital bleeding Pain Other systemic causes including: haematological, malignency, TB, infectious diseases Palpitations: consider other causes	SELF CARE HRT (discuss options & alternatives) CBT	Heavy periods Intermenstrual bleeding Post coital bleeding Pain Other systemic causes including: haematological, malignency, TB, infectious diseases Palpitations: consider other causes	SNRIs & SSRIs Clonidine Oxybutin Gabapentin Pregabalin Caution: women with cancer & interaction with Tamoxifen: paroxetine & fluoxetine	We may need to create public facing self care information (online / leaflet) - symptom by symptom See Nice guidance re. alternative options isoflavones 1.4.4 Palpitations - RED FLAG
Sleep problems & associated symptoms (Insomnia, exhaustion, difficulty concentrating, brain fog)	Sleep hygiene advice Consult your pharmacist for OTC options for sleep	Clinical depression Long Covid Primary insomnia Sleep apnoea	SELF CARE HRT (discuss options & alternatives) Focused CBT	Clinical depression Long Covid Primary insomnia Sleep apnoea	NICE CKS advice on short term mangement of insomnia	explore CBT - clarity on this - links?
Difficulty concentrating, lack of concentration, memory lapse (Brain fog)	CBT Add in.. Lifestyle advice	Normal ageing Long Covid Stress / Depression (Dementia. NB: rare)	SELF CARE HRT (discuss options & alternatives) Focused CBT	Normal ageing Long Covid Stress / Depression (Dementia. NB: rare)	Consider cautions	Brain fog for public - but caution, no evidence, definition

Optimal Pathway Toolkit (OPT) Prototype



Behaviour Change Models/ Frameworks…

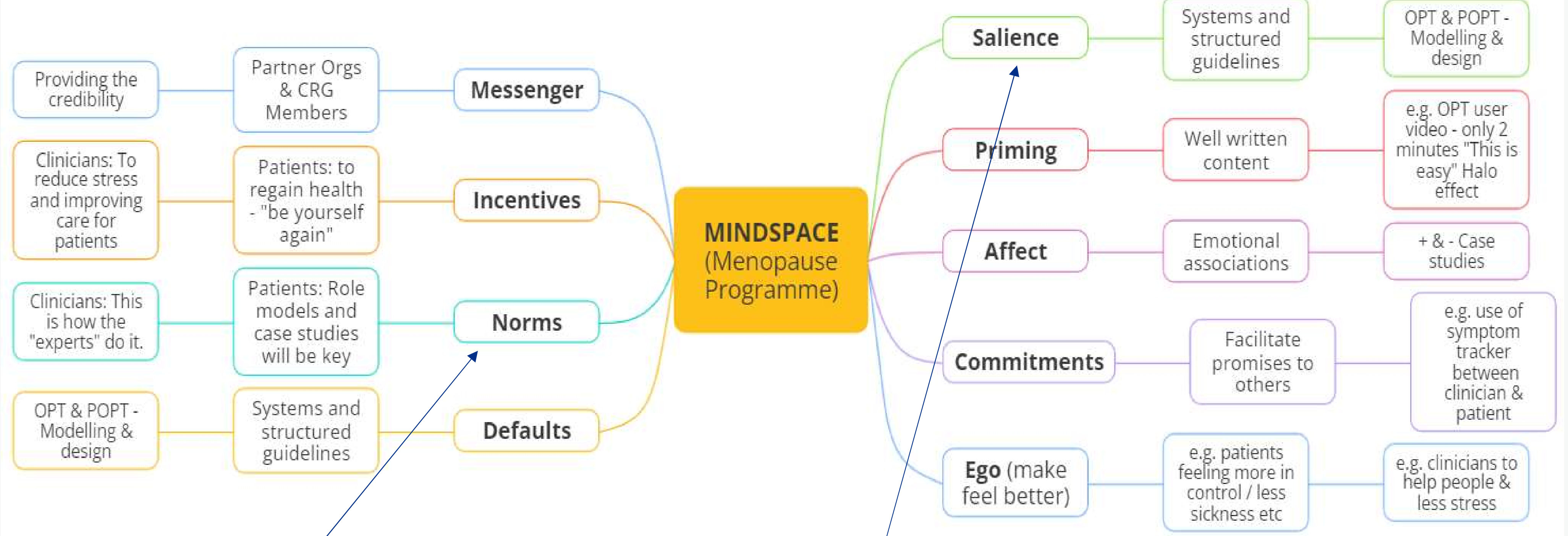
MINDSPACE is a checklist of influences on our behaviour for use when making policy

With this in mind, we set out nine of the most robust (non-coercive) influences on our behaviour, captured in a simple mnemonic – MINDSPACE – which can be used as a quick checklist when making policy.

Messenger	we are heavily influenced by who communicates information
Incentives	our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses
Norms	we are strongly influenced by what others do
Defaults	we 'go with the flow' of pre-set options
Salience	our attention is drawn to what is novel and seems relevant to us
Priming	our acts are often influenced by sub-conscious cues
Affect	our emotional associations can powerfully shape our actions
Commitments	we seek to be consistent with our public promises, and reciprocate acts
Ego	we act in ways that make us feel better about ourselves

…Underpinned by Process Engineering

MINDSPACE, e.g.s of need/use to improve Menopause



E.g. Discovery phase has proven that the current Norm on the frontline is a significant lack of awareness of Menopause good practice, and a further lack of awareness amongst the frontline that this is the case

E.g. Discovery phase has demonstrated that the guidance and advice that exists is either complex and not used (NICE), or used but not evidence-based – **The Optimal Pathway Toolkit (OPT) will resolve this**

Optimising Delivery: The Behaviour Change Phases

Behavioural Mapping

"What are the behaviour changes we want to occur?"

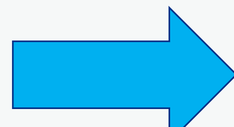
By population cohort (e.g. public, patient, frontline)

Behavioural De-Risking

"What are the motivators, enablers, barriers and drivers to adopting the new behaviours?"

"How do we design these into/ out of what we build?"

By population/ system cohort (e.g. public, patient, frontline, organisation, system, region, national (NHSEI, DHSC, Govt))



Behavioural Framing

"How do we mobilise the best model by conveying the best message in the best way for maximum uptake?"

Utilising:
Clinical Insight
Patient Voice
Behavioural Science
Process Engineering
Market research
Knowledge Management

Begin at the **end*** of the policy/ delivery chain, exploring both the barriers/ drivers to their adoption of the changes, and what they need from the rest of the policy/ delivery chain to enable them.

National – Regional – System (ICS) – Commissioner/ Provider – Provider teams – Frontline – ***Patient/ Public**

Behaviour change in healthcare

Behavioural science proves beyond doubt that

- The most effective way to identify the right things to do is to discover them via consensus, beginning with the common purpose of population and patient healthcare improvement
- Once you know the right things to try to help people to do (Evidence-based Positioning), the key to achieving this is to find the most effective way of encouraging people to **choose for themselves to change**
- At leadership and programme/ enablement level, this isn't by designing the solution ourselves and then trying to persuade the target audience to do it (whether the target audience is clinicians, support staff, managers or the population)
- It is by **working with** the target audience, **helping them** to find the solution, **asking them** how we can best help them to adopt it, and then doing that – Improving Value via Frontline Insight and Consensus…

Improving Value – Clinically led, Built by Consensus

Begin with clinical need

- Patient
- Clinician
- Population

Add in logistics and prioritise

- Workforce
- Finance
- Estates
- System

Imagine, Design and Build solutions

- Evidence-base
- COM-B
- Sustainable Healthcare Improvement

Where do we have the biggest opportunities for improvement?

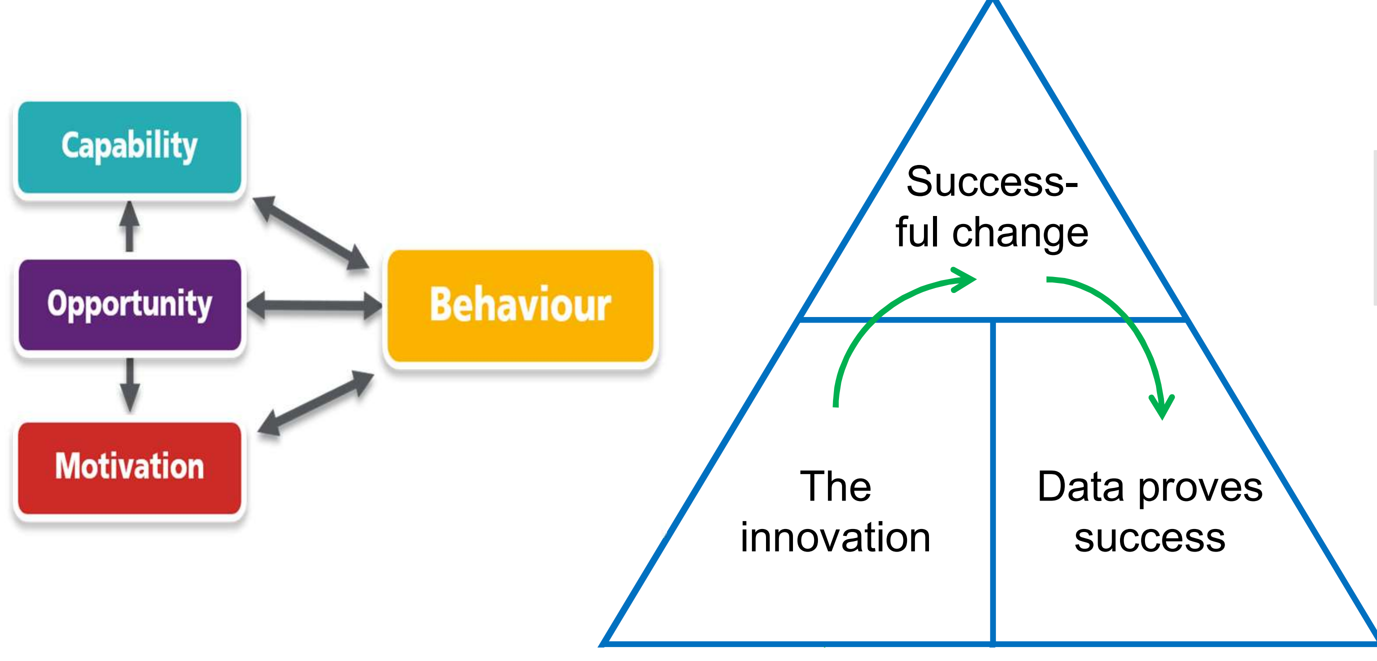
Where are we using the most effort and resources in not being as good as we can be?

Design, together, what we will look like when we are as good as we can be. Deliver.

Combine clinical and financial variation data

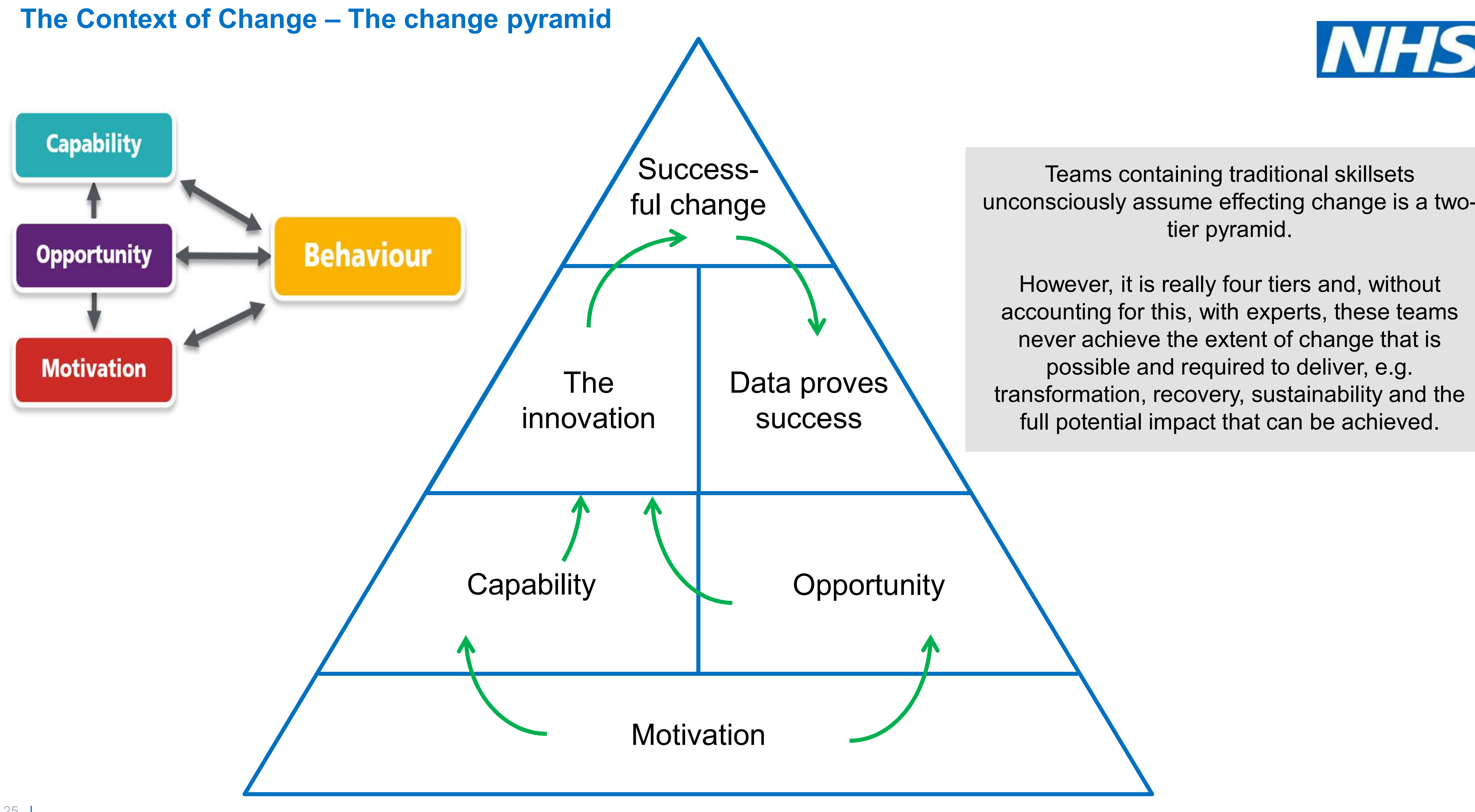
Align behavioural insights with QI

The Context of Change – The change pyramid



Teams containing traditional skillsets unconsciously assume effecting change is a two-tier pyramid.

The Context of Change – The change pyramid



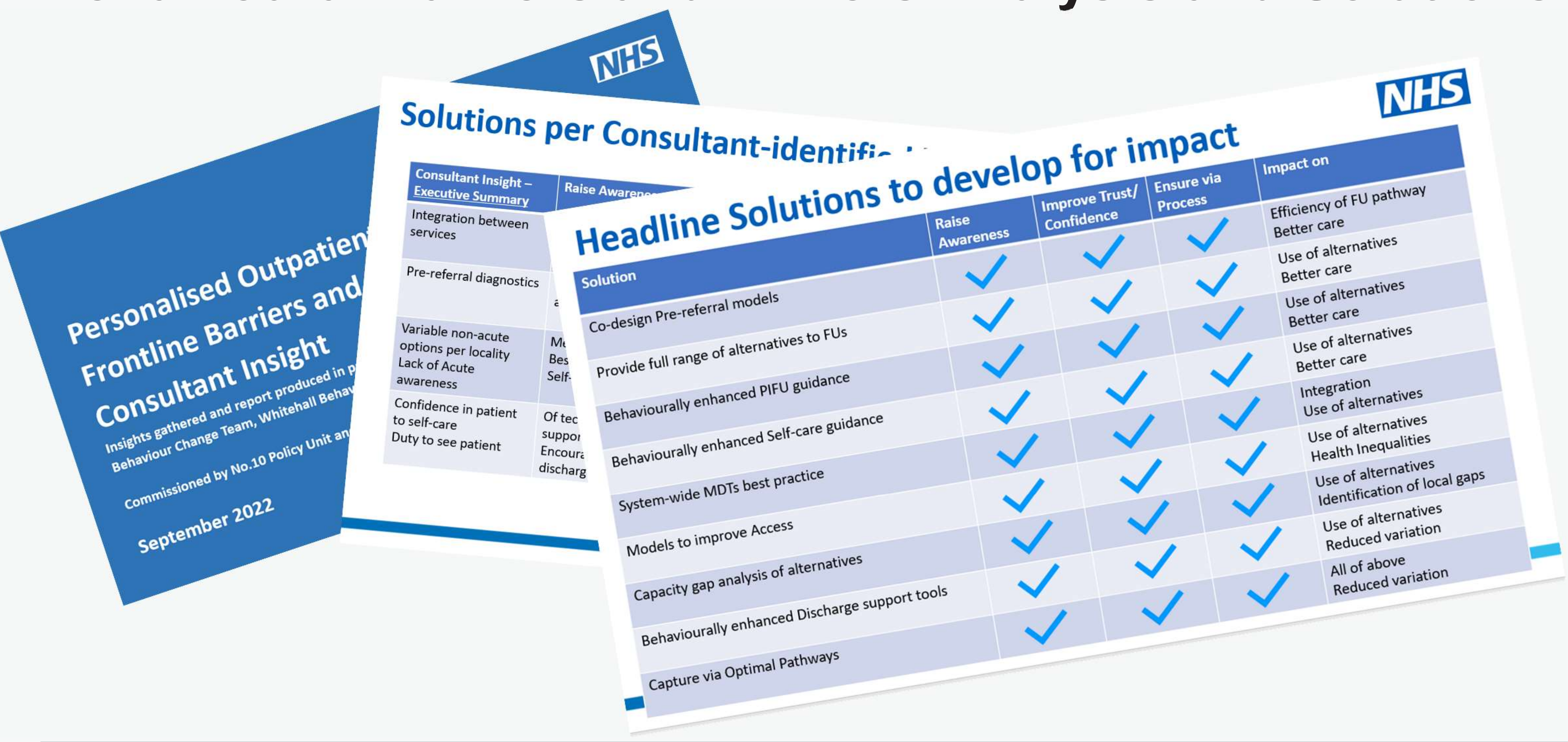
The context of change in Healthcare

Frontiers in Digital Health Journal article on how optimal spread and mobilisation is achieved, not by focussing on the change itself, but on the context in which the change occurs - https://doi.org/10.3389/fdgth.2022.727421

- *“Our thinking needs to shift from a focus on the <<improvement>> itself to how we bring about the changes needed... In practical terms, this means focussing on the changes involved to integrate… solutions into the delivery of services. In particular, it requires greater attention to the motivations, constraints and specific contexts that influence users and patients. The technical expertise of innovators therefore needs to be complemented by other forms of insight into change processes, including clinical and behavioural insight, process engineering and knowledge management.”*

Note: at the time of writing, the Behaviour Change Team were called the Sustainable Healthcare Team and are referenced as such throughout the article

Behavioural Barriers and Drivers Analysis and Solutions



Using Marginal Gains Theory – EDI Quick Wins or Culture Change?

It is very difficult to improve one thing by **100%**. It is much easier to improve **100 things by 1%**

Awareness

- Happy Teams are Productive Teams
- Benefitting from 'open thinking sessions'
- Tackling the 'status quo'
- The 'productivity gains' of EDI
- Educating on Microaggressions
- Tackling a culture which celebrates overworking
- Avoiding emphasising onerous expectations
- Tackling perceived threats
- Educating on system biases
- Managing Heuristics
- Pitching for action on EDI
- Mitigating common behavioural barriers

Recruitment

- Quantify 'Extensive Travel'
- Emphasise "on the job development"
- Remove Subjectivity
- Personalise EDI Statements
- Promote Flexible Working
- Consider Psychometric Testing
- Agree Criteria weighting
- Vary Selection Techniques
- Outcomes over Inputs
- Remove 'language skills'
- Avoid Assessor depletion
- Reduce Essential Criteria
- Target Networks
- Avoid 'Sales and Male Language'
- Consider utilising agencies
- Remove catch-all protections
- Guidance on supporting statements
- Avoid short deadlines

Progression

- Leading with kindness
- Encourage continuous professional development
- Use of inclusive language in everyday tasks
- Flat thinking hierarchies
- Safe spaces for open discussion
- Mitigating common behavioural barriers
- Desk side conversations
- Managing 'live allocation of tasks'
- Focussing on deliverables
- Provision of anonymised feedback
- Below the Surface checks

Motivation – Find the motivational hook

Productivity and Effectiveness Gains

Health and Wellbeing & EDI Gains

Focus for teams to achieve both from the same effort

IMPROVING VALUE VIA BEHAVIOUR CHANGE

CULTURE – Respect, Civility, Engagement			VALUE – Patient and Population Health		
EQUALITY, DIVERSITY, INCLUSION Enhance Impact*	**HEALTH AND WELLBEING** Increase Uptake	**HIGH IMPACT QUICK WINS** - Appraisals - Supporting Menopause	**WIDEN ENGAGE-MENT** Patient and Workforce	**CLINICAL LEADERSHIP** Key to success	**BUILD BY CONSENSUS:** WHERE TO FOCUS / WHAT TO CHANGE IMAGINE, DESIGN AND BUILD TOGETHER

THE BEHAVIOUR CHANGE APPROACH – Mapping, De-Risking, Framing:

What and who needs to change?	What do these people need from the rest of us, to enable them to change?	How do we best deliver this, with them, so that they can and do change?

COM-B: Identify and Remove Barriers – Identify and Enhance Enablers

*Enhance impact: Both the impact of EDI initiatives on the workforce and the impact of improved EDI on Improving Value (the better the EDI the better our delivery of healthcare)

Thank you

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