NICE PUBLIC HEALTH PROGRAMME GUIDANCE
BEHAVIOUR CHANGE

8th meeting of the Programme Development Group
11th July 2007, NICE Office, London.

MINUTES

Attendees:	*Members:* Charles Abraham, Mildred Blaxter, Vimla Dodd, Terence Lewis, Wendy Stainton Rogers, Martin White, Ann Williams, Karen Jochelson, Robert West (pm). *Co-opted members:* *NICE* Chris Carmona, Alastair Fischer, Jane Huntley, Mike Kelly, Lesley Owen, Catherine Swann, Clare Wohlgemuth, Sarah Dunsdon, Sue Jelley. *NICE observers* Midori Sato
Apologies:	David Woodhead, Ray Pawson, Christine Godfrey, Miranda Lewis, Miranda Mugford, Stephen Sutton, Vicky Cattell, Roisin Pill, Jennie Popay.
Audience:	None

Agenda Item	**Minutes**	**Action:**
1. Welcome and introduction	The Chair welcomed members to the 8th PDG meeting. Apologies were received from David Woodhead, Ray Pawson, Christine Godfrey, Miranda Lewis, Miranda Mugford, Stephen Sutton, Vicky Cattell, Roisin Pill, Jennie Popay. No changes were made to the group's declarations of interest.	
2. Minutes of last meeting	Agreed as a correct record.	
3. Finalising guidance	The group commented on the revised guidance. Page 4 and 5, Section 1 The Chair noted that the section had been revised extensively and queried why two recommendations were selected as the key priorities. It was noted that this format was not helpful to the reader, and did not accurately represent the guidance. The group were informed that there is a template for producing NICE guidance, and the key priorities section is a standard section in the template. The two recommendations were selected as key priorities in order to ensure the guidance is in the correct format. The format may be difficult to change but a view can be expressed	**NICE** **NICE**

to the Guidance Executive that it is not helpful in this case and it may be possible to omit it.

It was agreed that there should still be a statement at the beginning of the guidance – possibly now in the public health need and practice section - that clearly describes what it is and how it should be used. **Mike Kelly**

Page 6 and 7, Public Health Need and Practice

- It was suggested that the wording 'It is also very complex' is changed. It is not so much that change is very complex, as effecting changes in behaviour is not a straightforward undertaking. **NICE**
- The group agreed that they are happy to leave mention of childhood out of the section.

Pages 8 to 10, Considerations

- The Chair suggested that the theoretical points would be better in the appendix rather than in this section as it makes it look overly academic. **NICE**
- It was suggested that a consideration is inserted, referencing the theories and approaches that influenced the PDG, but their detailed descriptions should go back in the appendix.
- It was agreed that 3.5, 3.6 and 3.7 should remain in the section.
- It was noted that there is little discussion on psychological models of behaviour. It was recognised that 3.7 is good but there are problems with 3.9 and the wording from 'Consequently'… should be deleted. **NICE**
- It would be helpful to have a summary of the psychological models. Charles Abraham agreed he could help with this task. **Charles Abraham**
- It was pointed out that some of the examples aren't quite right, for example in 3.12, 3.19 and 3.20.
- It was agreed that families should be included in 3.12.
- It was suggested that something is included on social norms in 3.12. **NICE**
- The Chair asked that the last sentence of 3.14 be deleted.
- Martin White to send alternative wording to NICE project team on 3.14 and 3.16. He also suggested adding 'according to ethnicity, social position, gender' etc to 3.16. **Martin White**
- It was noted that 3.16 can use a more general term. Wendy Stainton Rogers to suggest alternative wording that would reinforce the need for the de-stigmatisation of behaviours. She also proposed that reference to service users be included in this section. **Wendy Stainton Rogers**
- It was agreed that the sentence 'no intervention will exist in a vacuum' should be removed in 3.19. **NICE**
- It was noted that 3.20 raises two separate points: knock-on effects, and the issue of intervening with motivated vs unmotivated individuals. It was agreed that the wording should be reconsidered. It was suggested that the first point should be tied in with 3.19 on unintended consequences.
- It was agreed that 3.22 should be framed more in health related behaviour terms.

- It was agreed that the value of faith networks should be included.
- It was agreed that 3.25 needs some re-wording. It was suggested that a better example is used – seat belt legislation was discussed - and the wording 'there is a lot' is made clearer. Martin White to suggest alternative wording to NICE project team.
- It was noted that there are problems with the use of the word 'evidence'. It was highlighted that it is important that the guidance does not exclude exploratory work. It was agreed that the term should be defined in the glossary in line with the methods manual.

It was agreed that the guidance should be clear in terms of what is meant by monitoring / evaluation in 3.30/31.

4. Finalising guidance

Recommendation 1:

- The Chair asked that the points in recommendation 1 be re-ordered into a more logical sequence. **NICE**

- The last bullet point should be amended to be explicit that any intervention should be based on the best available evidence.

- Single 'level' interventions can be effective and so the second indent should be worded carefully. **NICE**

- The issue of disinvestment in interventions where good evidence of effectiveness is lacking was discussed. It was suggested that the recommendation could use the phrase 'where the available evidence does not support claims about effectiveness'. It was noted that 'available evidence' could refer to a broad range of data and information from different sources. **NICE**

Recommendation 2:

- The Chair suggested that 'who should take action' for this recommendation should be expanded to include those outside of the NHS. **NICE**

- The Chair also suggested that the 4th bullet point be amended to include changes in services.

- It was agreed that the term 'self esteem should be deleted. **NICE**

- The last bullet point should be changed to read '…to help people wanting to change to do so'

- It was suggested that accessibility be included in this recommendation. **NICE**

Recommendation 3:

It was agreed that this recommendation, in its present form, is too brief and unsubstantial and should combine with parts of recommendation 2 **NICE**

Recommendation 4:

- It was suggested that age restriction be removed as an example of legislative interventions.

- It was suggested that the first part of the second bullet point should move to recommendation 1, but the second part should stay in recommendation 4. **NICE**

- It was noted that the costs of tailoring interventions could be significant. It was suggested that while in the longer term a great deal of the recommendations should be highly cost effective, investment would be required. **NICE**

- It was suggested that this investment would not necessarily be 'new' money, but would come from different (and more effective) use of existing funds eg training budgets.

Recommendation 5

The PDG discussed whether recommendations 5 and 6 should be combined or kept separate.

Members felt that it was incumbent of the PDG to set out clearly what appropriate training was, and that this was not an onerous task since it followed from the other recommendations.

It was felt that the language of 'competency' rather than training would be more appropriate. We should include cultural competency as a key characteristic.

The recommendation currently reads as though it only applies to NHS staff. Skills and high level training/competencies may be appropriate for Public Health Specialists, but the majority of behaviour change interventions are delivered by a much broader field than this. There is a spectrum of training need. Members of the PDG also noted that competence was not the same as qualification and that a team or group of people could be "collectively competent". **NICE**

A majority of the group agreed that it would be useful to try and produce a framework for training or competencies as part of the implementation tools for this guidance since practitioners want clear guidance on these issues. There could also be a recommendation that a schedule for public health training – in line with this guidance – needs to be developed.

Recommendation 6

The PDG noted that there was substantial overlap between this recommendation and the last bullet point of recommendation 1.

The PDG also felt that as it stands this recommendation is open to misinterpretation. The PDG was asked to be clear about exactly

what it was that they wanted to say in this recommendation.

The consensus was that, although there were difficulties with this recommendation, the overall tone of what it should say is that if there is evidence that an intervention does not work or is less effective than an alternative intervention then it should not be funded. Additionally, the popularity of an intervention or model is no guarantee of its effectiveness. Martin White offered to provide a form of words for this recommendation. **Martin White**

It was acknowledged that the nature and quality of evidence remains highly contested and that the guidance needs to acknowledge this. **NICE**

Recommendation 7

First bullet point:

- It should state that specific provision for evaluation and assessment should be made in funding applications and project plans.

NICE

Third bullet point:

- Should specify that the acceptability, feasibility, equity and safety of an intervention should also be evaluated.

Recommendation 8

First bullet point:

- It was agreed that that cost data be collected which allows cost-effectiveness to be determined properly. It was suggested, that on a routine basis, quality of life measures are taken so as to enable comparison of intervention benefits against other NHS interventions, which are competing for funds.

<u>Research Recommendations</u>

Recommendation 1

Additional bullet points:

- It was suggested that the recommendations should be that all randomised controlled trials be registered, and therefore in the public domain, so negative outcomes were made public. **Mike Kelly**
- Need to add a bullet point re reliability and validity of health behaviour measurements. It was felt that this should be addressed separately from 'a clear definition of what constitutes a health outcome'.

First bullet point:

- Second and third points: Need to be clearer re how 'a clear definition of what constitutes a health outcome' and 'the impact on health' relate.
- Fourth point: amend last parts of sentence to '…by socioeconomic status, age, gender or other sociocultural variables'.

Third bullet point::

- First point: The need to include social variables wherever possible was felt important for both adjusting for confounders and for determining differential effects. The wording should reflect that this should be done wherever possible in every study, with the impact on outcomes being measured. **NICE**
- Second point: reword to 'consider the impact of age and gender on the effectiveness of interventions.'
- Third point: Insert 'the needs of' before minority ethnic and religious groups.

It was noted that these research recommendations differ from other research recommendations which CPHE have produced. It was hoped that these research recommendations would have a powerful impact methodologically.

Recommendation 2

First bullet point:

- 'Focus' should be changed to 'Encourage research in areas where there are gaps in the social…'
- Fifth point: 'Predictability of health inequalities' is unclear, suggested that it be removed. **NICE**

Additional bullet point:

- While certain research methods should be encouraged, the development of innovative methodological approaches to the collation and synthesis of evidence on effectiveness should also be encouraged.

Recommendation 3

I Suggested that this recommendation be deleted.

Recommendation 4

Additional bullet points:

- A fourth bullet point should be added concerning the need for rigorous and transparent approaches for translating evidence into practice. The same level of rigour needs to be applied to different types of research methods.

Third bullet point:

- This needs to be clarified.

Fourth bullet point:

- This concerns both determining the transferability of findings across countries/communities and also about synthesizing different types of evidence, it should be reworded accordingly.

Recommendation 5

Bullet point one:

- First point: The word ‘All’ should be deleted.

NICE

Glossary

Martin White to provide definitions of various terms.

Martin White

Appendix D

This was felt to be much improved.

5. Implementation

The Chair introduced Julie Royce, Associate Director in the Implementation team at NICE.

Julie gave a brief update to the PDG on the support which the implementation team offered.

The team held a planning meeting during the consultation on the draft guidance. The meeting was very useful and looked at some of the key questions around implementing the guidance and its associated costs.

There are two main streams of work to support the guidance in the

implementation team: -

- Developing a supportive environment
- Providing practical support tools to sit alongside the guidance, including a slide set, costing tools, audit criteria (for NHS clinical audit) and implementation advice.

The team are also planning to talk to DH and DCLG about ways to embed this guidance into their policy and commissioning frameworks.

The PDG asked the following questions:-

Q: How do we establish the level of awareness of DCLG and how will the implementation advice be drawn together?

A: It is more about embedding in systems rather than anything else, and must be targeted to give most benefit. It is possible that there won't be any implementation tools. This will depend on the nature of the final guidance.

Q: The Dept for Children, Families and Schools also seems to have good synergy with this guidance, and given the focus on inequalities and the generic nature of the guidance, perhaps it would be relevant to the Equal Opportunities Commission?

A: This is related to a wider NICE project aimed at reaching far bigger audiences with NICE guidance. DCSF will be added to the list of organisations to be targeted. JR will also feed this into the comms team.

Q: Is it possible to provide models as part of the implementation, eg for Health Impact Assessment, Evaluation, or other things we are recommending?

A: This may be possible. It has been done with the obesity guidance. JR will organise a teleconference with Wendy Stainton Rogers, Martin White and Ann Williams to discuss the possibilities as soon as staffing issues within implementation have been resolved. Since the tools are published ten weeks after the guidance there is some flexibility time-wise.

6. Feedback from costings unit

Catherine Swann reported that the costing team at NICE had met with the technical team and had reached an agreement as follows:-

"The behaviour change programme does not lend itself to the normal costing template and report, and therefore an alternative way of presenting the possible budget impact of this guidance has been sought.

The guidance provides a set of guiding principles on how to plan, deliver and evaluate public health activities aimed at changing health-related behaviours. It does not cover interventions which aim to change specific behaviours, but underpins the way in which all public health interventions should be undertaken.

Field work undertaken by the team within public health indicates that the majority of public health practitioners already follow these

guiding principles, and therefore there will not be a large shift in the way interventions are performed. Consequently, we do not anticipate a significant resource shift for this specific programme guidance.

It was agreed at the meeting between public health and costing that a costing template was therefore not appropriate for this guidance, but that instead an extended costing statement should be prepared. This should highlight the two main areas that might have a resource impact at a local level (training and researching & evaluating projects), and also contain a consideration of the potential local cost issues in each of three areas, planning & design, delivery & implementation, and evaluation & assessment.

It was agreed that, subject to this process being agreed, a draft statement would be prepared and circulated to the public health team working on the behaviour change guidance, so that a collaborative approach could be continued."

The PDG suggested that perhaps a broader costing model is needed. It was also noted that the tone of the costing materials is vital. Cost benefits are likely to come in the longer term, and the short term costs of tailoring interventions to hard-to-reach groups are not insignificant, but are a good investment. Related to this, it was thought that people could make better use of existing resources and investments such as staff PDP's (personal development plans).

7. Communication and publication

- As yet there has been no briefing from the communication team, however, it is intended that towards late summer the communication team will plan launch of this guidance, consulting with the technical team and with the PDG.

- Given this guidance differs to other guidance; it has not yet been decided whether a press conference will be ideal. If a press launch is to be held, NICE will contact the PDG and training will be provided.

The PDG were asked to reflect on best method of dissemination for this guidance. **PDG**

- There will be a press release for this guidance; the PDG were advised that if contacted by the press, they must not answer questions but refer to the Communications team at NICE.

- Given the scale of interesting methodological, empirical and theoretical work discussed at the PDG meetings, a couple of options for capturing this thinking for an academic audience were proposed:

1. A longer piece, possibly a book, which captures much of the discussion not featured in the guidance.
2. Alternatively, an academic journal piece could be prepared, possibly for Social Science and Medicine.

There may be a possibility for a piece of joint working with the Kings Fund.

The PDG were asked to consider these ideas and to express whether they are interested in being involved.

- If the PDG are in favour of this additional work, NICE will put together and circulate a position papers regarding options.

- It was suggested that a productive way in which to prepare the foundations of a book is to hold a conference; the NICE conference in December might be a possibility.

- It may be necessary to prepare key position papers for different key journals (of differing disciplines) this could be the foundations for the book.

NICE will pick this up after all internal deadlines for the guidance has been met.

- The PDG were informed that Dr. Foster intends to write up the fieldwork for this guidance as a paper and present at the NICE conference in December.

The PDG were asked to forward any further comment based on today and to complete any action points resulting from today by the afternoon of 16th July 2007. **PDG**

The Guidance to be sent back to PDG on 23rd July until 30th July for comment.

All absent PDG members to be sent key dates asap.

The PDG were advised that an internal review of CPHE processes and methods is being conducted. This includes lessons learnt from this PDG, including how to deal with diversity of evidence, especially which moves away from empirical, for example, how to synthesise theoretical and modelling evidence with empirical evidence. NICE will prepare an account of how this has been done.

Evidence Statements

- The PDG were happy for the evidence statements not to be attached to the recommendations. This was deemed reasonable on the basis that the recommendations are not based solely on evidence statements but also on fieldwork, expert comments, theoretical material etc.

Appendix C

- A definition of ‘Inference Derived from Evidence’ (IDE) will be inserted back into appendix C as it is now part of the template.

8. Summary and close	On behalf of PDG members, Wendy Stainton Rogers, thanked Mildred Blaxter for her excellent job of Chairing the PDG meetings. Mike Kelly also thanked Mildred Blaxter on behalf of NICE. Both Mildred and Mike thanked the PDG members for their input to date in producing this guidance.