Public Health Guidance

Behaviour Change (partial update of PH6) Consultation on the Draft Guidance
Stakeholder Comments Table

5th June 2013 – 31st July 2013

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Alcohol Research UK	Introduction	P2	(This guidance does not cover any clinical and pharmacological methods of changing behaviour). The term "clinical" should be clarified. Many behaviour change interventions for alcohol problems and dependence are implemented in a clinical setting.	Thank you for your comment. The text has been revised to state: "Clinical and pharmacological methods of changing behaviour that have no public health or health promotion element." Please note that interventions for alcohol dependence were not covered in the evidence reviewed for this guidance.
Alcohol Research UK	Recommendation 3	P7	(Ensure time and funds are allocated for independent evaluation) Research organisations such as Alcohol Research UK are usually a good source of advice on methodology and access to experienced researchers	Thank you for your comment.
Alcohol Research UK	Recommendation 12	P17	(Training: Ensure time and funds are allocated for independent evaluation) For monitoring purposes a video of an intervention is now relatively easy to make. This can then be assessed at leisure using a list of competences. Validation of a scale for rating the process of delivery of psycho-social treatments for alcohol dependence and misuse: the UKATT Process Rating Scale (PRS).	Thank you for your comment.
Alcohol Research UK	Recommendation 15	P20	(Ensure practitioners develop skills in encouraging and enabling people to change and manage their own behaviour)	Thank you for your comment. Please note that we are unable to

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			Research on interventions for alcohol related problems provides supportive evidence. For example the Mesa Grande, a review of alcohol interventions, identifies the following in the top 10 of 48 interventions: brief interventions, motivational enhancement, community reinforcement, self change manual, behavioural self-control training, behaviour contracting, social skills training, and behavioural marital therapy. (**Raistrick**, D., **Heather**, N. and **Godfrey**, C. (2006) Review of the effectiveness of treatment for **alcohol** problems, (London, National Treatment Agency))	accept or review additional evidence at this stage.
Alcohol Research UK	3.5	P25	(Suppliers and manufacturers could, for example, provide (free of charge) useful data to aid understanding about behaviours such as alcohol use or eating patterns) This is a controversial suggestion. For example the main influences on excessive alcohol consumption are affordability, accessibility and marketing. These are the areas to focus upon rather than aids to understanding.	Please note that the considerations are not recommendations. Considerations illustrate the range of issues the PDG has considered in developing the recommendations. Whilst they recognised the issues and sensitivities around the use of commercial data and information, the PDG did not feel this was a controversial comment concerning consumer behaviour and how commercial organisations may be able to help researchers understand this better.

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Alcohol Research UK	3.15	P28	(the first recommendation highlights the need to have an integrated programme of population, community, organisational and individual-level behaviour-change interventions.) We strongly agree with this. For alcohol misuse this would involve local and national policies focusing upon affordability accessibility and marketing.	Thank you for your comment.
Alcohol Research UK	3.18	P28	(The PDG was concerned that if private companies were commissioned to provide a behaviour-change service they may not share data because of commercial interests) This should be a stronger statement e.g. “private companies should not be commissioned to provide a behaviour change service if there is a conflict of interest or if they do not agree to share retail data on consumption patterns or other data on processes and outcomes”	Thank you for your comment. The consideration (4.21) has not been changed as this reflects the deliberations of the PDG. Considerations are not recommendations. Please note that recommendation 3 recommends commissioners of services place a requirement in service specifications for companies to “collect accurate, standardised and comparable routine data on behaviours that affect health and wellbeing” and for this to be shared with commissioners, local and national

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				organisations
Alcohol Research UK	3.39	P32	(The PDG was concerned that training programmes still describe the stages of change model (also known as the transtheoretical model) as a theoretical basis for behaviour-change interventions. The PDG wanted to highlight that, although it may help practitioners to understand their client's experience of behaviour change it is not a theory that explains and predicts such change) This may be so but it should be emphasised that "readiness to change" is a useful concept that should be assessed before and during an intervention (Post-treatment stage of change predicts 12-month outcome of treatment for alcohol problems. Heather, N. ; *McCambridge J.* ; on behalf of the UKATT Research Team, *Alcohol & Alcoholism*, 2013)	Thank you for your comment. The PDG did not agree with the use of the term 'readiness to change' due to its association with the transtheoretical model, however the PDG recognise that there are times when people may be more open to change, as highlighted in recommendation 8.
ACTSO (Association of Chief Trading Standards Officers)	Recommendation 4	8	ACTSO feel that Local Authority Trading Standards Services should be named as a supporting organisation, as another local authority service linked to Public Health which could be commissioned to deliver certain interventions around behaviour change. LATSS already share intelligence of premises selling to people who are facing interventions and the service can provide support, in terms of education to retailers, and take further action to prevent the supply of products including alcohol and tobacco to the group of people these recommendations relate to. ACTSO would also remind NICE of the impact of illicit/ illegal tobacco and alcohol to this age group, particularly in more deprived communities, which will have an on-going impact on their health in the future and undermine any behaviour drivers like price/ taxation increases, and reduce the potential efficacy of other interventions.	Thank you. We strive to use generic terms to describe organisations so as to be inclusive as possible, rather than singling out individual organisations by name. In response to your comments concerning illicit tobacco and alcohol sales and usage, this is beyond the scope of this guidance.
ACTSO (Association of Chief Trading Standards Officers)	Recommendation 5	9	There is reference in this section to taking into account key stakeholders when planning behaviour change interventions. Local Authority Trading Standards Services will have some useful data relating to the locality in which they	Thank you for this information. This sort of detail would not be

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			operate and should be considered as part of this process. They could be commissioned for interventions, particularly those requiring changes in business behaviour.	included in a recommendation: we hope commissioners and providers will draw upon a range of sources appropriate to their area.
ACTSO (Association of Chief Trading Standards Officers)	Recommendation 7	12	The behaviours covered in this document are: alcohol, diet, physical activity, sexual behaviour and smoking. The new guidance is aimed at people aged 16 and older. As such trading standards services already have a role in relation to the sale of alcohol and tobacco products to those in the 16-18 years of age bracket As Trading Standards work with retailers and other businesses, there is an opportunity to provide brief interventions during those contacts e.g. providing literature to retailers to provide to customers regarding stop smoking services or carry out work in conjunction with Drink Aware or healthy eating promotions. Whilst this is not the normal "brief intervention" model, directly engaging with someone whose behaviour may need to change, it could provide a basis for wider engagement with the population. Obviously this is not one of trading standards core functions but it represents an opportunity to deliver a brief message.	Thank you for your comment. Trading standards officers would be included under providers of wellbeing services as supporting the welfare of individuals.
ACTSO (Association of Chief Trading Standards Officers)	Recommendation 7 (cont)	12	The guide deals with behaviour change at population, community and individual levels. A local authority service can address behaviour change at community level and existing Community Alcohol Projects (CAPs) and similar campaigns have proved successful in that respect. Responsible retailer schemes, promoted by some trading standards services, address the supply	Please note that this guidance does not deal with behaviour change at population and community levels. NICE

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			of both alcohol and tobacco to underage purchasers at a community level. The restriction on ready accessible supplies of alcohol and tobacco supports other intervention strategies and reduces peer pressure to consume these products, thereby reducing the chance of youngsters developing a dependency.	public health guidance PH6 addresses community and population level intervention, and we hope to update these aspects of the guidance in the near future.
ACTSO (Association of Chief Trading Standards Officers)	Recommendation 7 (cont)	12	The guidance could make it clearer to Directors of Public Health, Clinical Commissioning Groups, Health and Wellbeing Boards etc that trading standards services may already address some of these issues as part of their core activities and that LATSS would welcome increased partner involvement as part of an holistic approach. There is a risk that the potential funders only recognise LATSS for their expertise in enforcement not their broader expertise in communicating messages and other forms of delivery.	Thank you for your comment. Trading standards officers would be included under providers of wellbeing services as supporting the welfare of individuals. Specific providers are not singled out.
ACTSO (Association of Chief Trading Standards Officers)	General		Could we put something in about nutrition and diet bearing in mind the current policy of Government around reducing obesity and improving meal provision in schools. Welsh Heads of Service carried out an across Wales survey about 2-3 years ago which looked at meal provision in residential, care and nursing homes. The results were startling with some homes providing a total days calorific value of below 800 and others over 3500 (1950 being the expected value). Obviously salt, fat and sugar levels were similarly diverse. When interviewing Nutritionists at a Local Health Board they had already recognised the problem of mal-nourished residents entering the hospital system. Welsh TS are now working with Welsh Government and their Local Health Board to produce a Unified Menu Planning System which will eventually be made available free to a wide variety of catering facilities including those listed	Thank you for your comment. It was decided that this guidance would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in

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			above together with meals on wheels, school meals services etc. Welsh Government view this new system as being complementary to their recently developed hospital menu system.	more detail: You can find the full list of published NICE public health guidance here.
ACTSO (Association of Chief Trading Standards Officers)	General (cont)		In the original guidance there was no lower age limit for the recommendations. The new guidance is aimed at people aged 16 and older. The document states that this is to take into account the fact that certain behaviours (such as sexual behaviour) are legal or prevalent among young people aged 16 and 17. This belies the importance of the education and interventions that can and are carried out with young people below 16 years of age, for example, the valuable work undertaken as part of PSHE education. Previous 'adults only' central targets for smoking cessation seemed to remove the impetus for supporting tobacco education for those under 16 and working with young people to quit. Is separate guidance for those under 16 planned but not mentioned? Significantly, not including those under 16 would mean that there is no drive to collect routine data on health-related behaviours (such as smoking and alcohol) from those under 16.	Thank you for your comment. We agree with the point that you make, however there is always a balancing act to be made when developing guidance to ensure that we can cover relevant evidence within the time and resources available for a piece of guidance. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
ACTSO (Association of Chief Trading Standards Officers)	General (cont)		The document states that community or population-level interventions to change behaviour that are not based on choice architecture are not included and that these will be the subject of future guidance updates. It may be that, on this basis, community-wide and preventative elements are not covered by this guidance however it also states that strategies and policy should aim to improve everyone's health. As regards 'Planning behaviour-change interventions and programmes' it would be useful if examining existing initiatives by and working together with	Thank you for your comment. The guidance does not cover any community or population interventions – recommendation to ensure within policy and strategy these are considered does not

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			other public sector and third sector bodies could be explicitly included as well as referencing 'communities and researchers'. There does not seem to be mention of the use of community champions, individual volunteers or educating / empowering other professionals to undertake 'brief interventions'. For example, Youth Workers and Surestart staff being trained as Stop Smoking Advisors.	indicate which interventions but is included to ensure that these are taken into account, the details of which interventions are recommended at these levels will be subject to future guidance. NICE public health guidance PH6 addresses community and population level intervention, and we hope to update these aspects of the guidance in the near future. The first bullet in recommendation 5 provides examples only, it is not an exhaustive or prescriptive list.
BHA for equality in health and social care	1	14	First point under What action should they take? Amend to include: This includes addressing the specific needs of people in regards to sexuality, culture, gender, faith and any type of disability.	Thank you for comment. We have amended the recommendation to state 'Any specific needs with regards to sexual orientation, gender identity, gender, culture, faith or any type of

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				disability.'
BHA for equality in health and social care	1	14	Second to last point under What action should they take? Amend to include: Discuss what the likely impact on their own and that of those they are in contact with will be if they do make changes.	Thank you for your suggestion. The recommendation has been amended to state 'Discuss what the likely impact will be if the participant makes changes to their behaviour (in terms of their health and wellbeing and the health and wellbeing of those they are in contact with).'
BHA for equality in health and social care	1	15	Social support - to include peers and relevant support organisations/groups	Thank you for your comment. Further detail on social support is provided in the glossary.
BHA for equality in health and social care	1	18	To expand – can address health inequalities by tailoring interventions to people's specific needs, including their cultural, social and economic needs – also include sexuality and faith	Thank you for your comment. The recommendation has been amended to state 'can address health inequalities by tailoring interventions to people's specific needs, including their cultural, social and economic needs and other protected characteristics'

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BHA for equality in health and social care	1	20	Recommendation 16 to include support mechanisms for staff delivering behavioural change interventions eg supervision (clinical and/or non-clinical), support and guidance	Thank you for your comment, supervision is covered in recommendation 2 and 11.
BHA for equality in health and social care	1	21	To ensure effective and independent evaluation, funding and contract length needs to be proportionate.	Thank you for your comment. This would be for local commissioners to decide on. This is not the level of detail we would provide in a recommendation.
British Dental Association	General		Refer to tobacco use rather than smoking and thus include smoke-free tobacco use.	Thank you for your suggestion. The evidence reviewed for this guidance was on smoking only, therefore it would not be appropriate to use the term tobacco use.
British Dental Association	General		Patient assessment of different types of intervention and their effectiveness should be integrated with the use of any behavioural change strategy.	Thank you for your comment. Evaluation recommendations are made in recommendation 16.
British Dental Association	Recommendation 7	12	Brief interventions need be delivered in an appropriate and timely manner. Clinical judgement should be used to determine when and which brief interventions should be delivered at each patient contact. Brief interventions will only be effective if there is a clearly defined and well-	Thank you for your comment. Recommendation 9 covers the delivery of interventions and

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			resourced referral pathway.	addresses the issues you raise.
British Dental Association	Recommendation 13	17	Training providers should be added to the list of those who should take action	Thank you for your comment, training providers are included: 'Royal colleges, faculties, schools, voluntary sector and sector skills councils that train or accredit health and social care professionals'
British Dental Association	Recommendation 17	21	There is confusion between the use of outputs (which relate to the behavioural intervention and outcomes (which relate to the success of the intervention). There should also be a recognition of the variable nature of the outcomes which may be difficult to characterise as simply success or failure	Thank you for your comment. We have provided details of outputs. Please note that this guidance is not intended to be recommendations on how to undertake research. Please note that implementation tools that support this guidance include a Podcast on how to recognise and use good quality evidence in public health
British Dental Association	Recommendation 18	22	The development of a central repository of behaviour-change training material needs to have a specific aim.	Thank you. Your suggestion has been reflected in the redrafting of the recommendation, and an additional consideration (4.56)

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				addresses the sharing and dissemination of evidence.
British Heart Foundation	General	X	The British Heart Foundation (BHF) is the nation's leading heart charity. Our vision is of a world in which no one dies prematurely of heart disease. There are over 2.3 million people in the UK living with coronary heart disease.[1] We raise awareness of the benefits of a healthy lifestyle, advocate for the right environment to make the healthy choice, the easy choice and provide information and support for people at risk of living with heart disease. The BHF welcomes the opportunity to respond to this guidance. Behaviour change is an important component of programmes that will help people make a number of lifestyle changes that can help reduce their risk of coronary heart disease. We welcome that this guidance helps clarify what techniques should be used, when and by whom. If you have any queries about this response or would like more information please contact Amy Smullen, Policy Researcher smullena@bhf.org.uk	Thank you for your comments.
British Heart Foundation			[1] British Heart Foundation (2012) *Coronary Heart Disease Statistics* http://www.bhf.org.uk/plugins/PublicationsSearchResults/DownloadFile.aspx?docid=e3b705eb-ceb3-42e2-937d-45ec48f6a797&version=-1&title=England+CHD+Statistics+Factsheet+2012&resource=FactsheetEngland	Thank you.
British Heart Foundation	General	X	This draft guidance, when compared with the previous NICE Public Health Guidance 6 on behaviour change, does move the quality of advice forward and offers a considerable amount of guidance. As a result the guidance is	Thank you for your comment. It can be a challenge to balance the

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			content-heavy and at points the necessary cross-referencing is confusing. Therefore the Programme Development Group might reconsider the ordering of the recommendations particularly relating to the transitions from Commissioning principles (Recommendation 2) and the sequence of planning (5) design (6) Delivery (7), training (12) and evaluation (3 and 17). The current sequencing does not seem to offer a smooth flow or continuity and changes from broad principles to detail. (Page 12) The Programme Development Group might also wish to look at ways of providing more clarity and continuity in the document relating to the evidence to support the relative effectiveness of the different interventions.This is an important consideration, but references and evidence is scattered and not cohesive.is an important consideration, but references and evidence is scattered and not cohesive.	level of cross-referencing to other recommendations in a guidance document against accessibility; and some stakeholders have requested more cross-referencing. That said, we have with this final guidance introduced a new template structure which aims to make the recommendations clearer and more accessible to the reader, and the cross referencing has been amended. In relation to ordering of the recommendations, these have been reordered. Please note that recommendations will also be available within NICE pathways, in which all recommendations can be seen together under sub-headings.

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				In relation to evidence, all supporting documents – reviews and expert testimony will be available on the NICE website pages for this guidance. Links to evidence are made explicit for each recommendation in a separate document supporting the guidance (previously section 9 of the draft guidance). Recommendations themselves are not written referencing every piece of evidence.
British Heart Foundation	General	X	The guidance reveals good evidence in support for physical activity interventions but is rather equivocal about broader interventions where physical activity is considered alongside another behavioural intervention, such as diet or smoking.	Thank you for your comment. This guidance does not provide specific recommendations for a particular behaviour – instead we aimed to look across topics for evidence about cross-cutting effectiveness. For detailed information and recommendations on specific topics, please

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				refer to topic specific NICE public health guidance which is able to cover evidence on interventions for a particular behaviour in more detail.
British Heart Foundation	Introduction	1	The BHF would welcome reference to the further/work research in Choice Architecture as it is of increasing interest to the promotion of physical activity.	Thank you for your comment; this is referenced in consideration 4.61.
British Heart Foundation	Introduction	1	The guidance should take into consideration that young people engage in certain behaviours which require intervention such as smoking before the lower age limit of the guidance. Diet and physical activity intervention should not have an age limit imposed. Intervention should be based on individual need and not on lower age limits.	Thank you for your comment. We agree with the point that you make, however there is always a balancing act to be made when developing guidance to ensure that we can cover relevant evidence within the time and resources available for a piece of guidance. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
British Heart Foundation	Recommendation 1	5	The BHF welcomes the recommendation to identify a named strategic local authority lead for specific behaviours (e.g. physical activity) which will promote	Thank you for your comment. Recommendation 1 states

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			a consistent and clear approach to strategy. The BHF has been working with local communities and public sector bodies for the past five years, through the BHF Hearty Lives Programme. We have found that interventions that work with communities rather than supporting communities achieve much greater traction. The BHF recommends that this recommendation in addition to linking behaviour change to evidence and equity, there also needs to be explicit that behaviour change interventions will improve health outcomes.	'Ensure policies and strategies aim to improve everyone's health and wellbeing.' And 'Identify the behaviours the strategy will address, and the outcomes it aims to achieve.' Health outcomes are mentioned throughout the recommendations.
British Heart Foundation	Recommendation 2	6	The BHF welcomes this recommendation and its dedication to ensure health inequalities will not increase and where possible reduce. In addition when commissioning the guidance should consider that the BHF Hearty Lives Programme[2] has found that the intervention is only likely to be effective if there is appropriate project management – i.e. someone responsible for the intervention.	Thank you for your comment. We are unable to accept or review additional evidence at this stage.
British Heart Foundation			[1] British Heart Foundation (2012) *Hearty Lives Final Evaluation Report: National evaluation of British Heart Foundations Hearty Lives Programme*. http://www.bhf.org.uk/pdf/HL%20national%20evaluation%20FINAL%20report.pdf	Thank you, but we are unable to accept or review additional evidence at this stage. However, NICE public health guidance is currently reviewed for update every three years and, where new

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				evidence is available that falls within our original scope, it will be taken into account during the update review process.
British Heart Foundation	Recommendation 3	7	The BHF welcomes the recommendation to commission interventions that are proven to be effective over the long term. This may require substantial changes to ensure that commissioning moves away from short term "quick hits" towards sustained interventions. The BHF is mindful that the evidence that supports brief interventions will always be more attractive as it is seen to be cheaper. The BHF strongly agrees that interventions for which there is no evidence should be adequately powered and evaluated. The BHF has an evaluation framework in place to evaluate interventions in the projects we fund (available on request)	Thank you for your comment.
British Heart Foundation	Recommendation 6	11	The BHF believes that the recommendation on documentation/manuals/protocols and design will be very valuable as there is a lack of good quality guidance in the professional domain, partly as a result of researchers not communicating findings on evidence-based practical guidance on intervention design.	Thank you for your comment.
British Heart Foundation	Recommendation 5	9	The BHF supports the recommendation relating to intervention fidelity. We believe this will add to the effectiveness of interventions as experience suggests this is not currently part of programme planning	Thank you for your comment.
British Heart Foundation	Recommendation 6	15	The BHF has found that the design of the behaviour change intervention should also define the outputs and outcomes that might be expected – both direct and indirect outcomes and outputs. This could include resources, manuals, additional learning, as well as the direct impact on behaviour change for the individual.	Thank you for your comment. Outcomes and objectives are addressed in the guidance.
British Heart Foundation	Recommendatio	13-14	This recommendation implies the intervention is at an individual level however	Thank you for your

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	n 8		the BHF has expertise of working with groups of individuals and groups (e.g. work place interventions), peer-led intervention and web based support (e.g. WeQuit web site). We have found that client assessment is not possible and necessary in these situations. This recommendation may also be better described as design recommendations rather than delivery as assessment of service, where applicable, should form part of design process.	comment. This guidance is for individual level interventions; while an individual-level intervention can be delivered to groups, we would expect the assessment of a person's behaviour and needs to be completed by an individual on their own and for this information to be available when delivering an intervention. Where interventions involve assessment then we would expect this detail to be provided in manuals, etc as detailed in previous recommendations. This recommendation is about the delivery of assessment of a person's behaviour and requirements for an intervention.
British Heart Foundation	Recommendatio	13-14	As above this recommendation may be better described as 'design' rather	Thank you for your

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	n 9		than 'delivery'. This would firmly root the individual needs in the creation of an intervention. When catering to individual needs the guidance needs to reflect that there may be a disparity between professional and public preferred outcomes. For example, participants may seek alternative outcomes after intervention, such as wellbeing, whereas the professional outcome would focus on improved health.	comment. All recommendations on delivery should be reflected in the design process as they constitute what makes up the intervention. The guidance recommends that a person centred approach is taken which would reflect an individual's preferences.
British Heart Foundation	Recommendation 10	15	The BHF queries the basis for the inclusion of some behaviour change techniques but not others. The guidance would therefore benefit from further detail on the criteria used to determine which behavioural change techniques are appropriate. The BHF has also found that motivation is a key additional factor in supporting or impeding behaviour change interventions. This should be mirrored throughout the techniques employed.	Thank you for your comment. The evidence base for these specific techniques is based on our systematic evidence reviews (which will be available via the web page for this guidance under 'supporting documents') at publication, and highlighted in a supporting document for this guidance (previously in section 9 of the draft guidance) which links

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				recommendations to the evidence and is discussed in the considerations. Motivation has been highlighted in other recommendations on delivery.
British Heart Foundation	Recommendation 11	16	As highlighted above, the BHF has found that the key to the longer term maintenance of behaviour change is dependent upon motivation felt by the participant. This should therefore be reflected in the on-going monitoring and feedback offered to participants. To ensure on-going support for past participants this recommendation needs to relate more closely with Recommendation 2 as the support needed to ensure maintenance needs to be considered in the commissioning.	Please see the response above. Please note that all the recommendations in the guidance should be looked at together rather than in isolation; and Recommendations are written in a way to avoid repeating information in other recommendations where possible.
British Heart Foundation	Recommendation 12	16	The BHF supports this recommendation and would welcome greater clarity on funding that will be secured to ensure appropriate training and access to specialist trainers for those offering interventions. Greater clarity would also be welcome on how staffing and time would be ensured to meet local needs.	Thank you for your comment. NICE does not make decisions on funding, nor on how staffing is organised as these things may vary locally according to population needs and local structures and management. Please see implementation tools

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				for training support.
British Heart Foundation	Recommendation 13	17	The BHF suggests that this recommendation is extended to include continuing professional development of the existing workforce.	Thank you for your comment. The recommendation does state that this is part of CPD.
British Heart Foundation	Recommendation 14	18	The BHF recommends that a definition of 'behaviour change practitioner' is added to the glossary. We would also welcome that 'providers' of behaviour change training should understand the principles of education in addition to the principles of behaviour change to ensure high quality, effective training.	Thank you for your suggestion, there is now a glossary definition of behaviour change practitioner. We would expect training providers to understand the principles of education and do not feel it is necessary to add this to the recommendations.
British Heart Foundation	Recommendation 17	21	Whilst the BHF supports the framework for evaluation proposed within the guidance, there appears to be a disparity between this recommendation and recommendation 3 where it seems that evaluation and research are being used interchangeably. Greater clarity would be appreciated on whether interventions for which there is no evidence be evaluated or researched.	Thank you for your comment. Evaluation is a part of research. The term 'research' has not been used in the recommendations so we are not sure where the confusion is arising from. Recommendation 4 and 16 provides detailed recommendations

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				concerning evaluation.
British Heart Foundation	Recommendation 18	22	Research shows that voluntary organisations such as the BHF are well placed to support behaviour change interventions such as our campaigns aimed at encouraging people to quit smoking – such as No Smoking Day. The public responds well to the BHF as a trusted voice which has authority to promote behaviour change.	Thank you for this information on your organisation.
British Heart Foundation	Considerations	24	The BHF questions whether there is a need to provide more detail and/or any evidence relating to theoretical frameworks if they are important to intervention/programme design. As these frameworks change and evolve over time professionals need guidance in this area	Thank you. The guidance has highlighted the need for further work in this area – please see recommendations for research.
British Heart Foundation	Glossary	37	'Choice architecture' as a concept needs further and more detailed explanation.	Thank you. A glossary definition for choice architecture has been provided which also contains reference to literature with further details.
British Heart Foundation	3.17	28	The BHF feels the guidance needs to address the lack of evidence given the current trend towards interventions to promote whole health (e.g. Active Ageing, wellbeing) which include more than one behaviour.	Thank you. The guidance has highlighted the need for further work in this area – please see Recommendations for research and Gaps in the evidence sections.
British Heart Foundation	3.27	31	The BHF queries whether there is there any evidence supporting the effectiveness of those other than GPs leading behaviour change interventions	Yes, there is evidence of effectiveness. For further information please see the evidence reviews

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				which will be available at publication via the web page for this guidance.
British Heart Foundation	3.39	32	The legacy of the Stages of Change model persists and the Programme Development Group might wish to consider how this change of thinking might be brought about in consideration with our comments above on theoretical frameworks.	Thank you.
British Heart Foundation	4	34	Taking into consideration points above relating to change and theoretical models being used to underpin intervention design, the BHF recommends further research into this area that would offer good quality guidance on appropriateness/best fit.	Thank you. The guidance has highlighted the need for further work in this area – please see recommendations for research.
British Nutrition Foundation	General		The BNF welcomes the planned guidance on behavioural change techniques in individual-level interventions as an addition to the existing guidance on behaviour change.	Thank you.
British Nutrition Foundation	General		The BNF would welcome additional guidance for interventions aimed at children and young people under the age of 16 years, to provide direction on appropriate methods and age-specific considerations.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
British Nutrition Foundation	General		It may be useful for the guidance to offer some examples of behaviour change theories (e.g. transtheoretical model stages of change), methods of characterising behaviour change interventions (e.g. behaviour change wheel) and more examples of behaviour change techniques and/or interventions (e.g. motivational interviewing) to better support interpretation. In particular, it would be useful for the guidance to provide some more explicit	Thank you for your comments. Please note that the guidance does not support the use of the transtheoretical model. Please see the considerations section. A

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			advice on which BCTs are particularly appropriate for specific behaviours e.g. smoking cessation vs dietary change.	lack of evidence concerning the link between theory and effectiveness of behaviour change interventions is noted as a gap in the evidence and a research recommendation has been made. A decision was made by the PDG not to make recommendations in relation to specific behaviours as these are subject to other NICE guidance.
British Nutrition Foundation	Recommendation 6	11	Further clarification of what is meant by a 'manual' is needed. The BNF is supportive of the publication and dissemination of intervention protocols to better support the replication and investigation of behaviour change intervention components. However, the term 'manual' might be interpreted as a practitioner-level instruction manual (for use during intervention delivery) - there is evidence from some behaviour change interventions that this decreases intervention effectiveness, for example in the case of motivational interviewing. (see: Hettema J, Steele J, Miller WR. Motivational interviewing. Annu Rev Clin Psychol;2005;1:91–111) Perhaps the term 'protocol' would better convey the purpose of document.	Thank you for your suggestion. The recommendation has been amended to provide further details on manual content. The guidance also highlights the need to tailor an intervention to someone's specific needs and to take a person centred

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				approach.
British Nutrition Foundation	Recommendation 7	12	The BNF is concerned about the definition of an 'extended brief intervention' and how this fits practically into a practitioner's role. A large proportion of NHS health care professionals (HCPs) fall into the category of *"having the potential to provide medium-intensity interventions (extended brief interventions)"*. The definition provided for an extended brief intervention states that it *"usually lasts more than 30 minutes"*. With many HCPs expected to provide appointments lasting no longer than 10 - 20 minutes, incorporating an extended brief intervention may not be realistic in day-to-day practice, leading to many HCPs falling short of this recommendation.	Thank you for your comment. The recommendation has been amended.
British Nutrition Foundation	Recommendation 15	19-20	As practitioner skills are a key aspect of any behaviour change technique, the recommendations on practitioner training are very welcome. The BNF would welcome further detail on training that incorporates the delivery mode (e.g. directive vs patient-led) and the practitioner approach/characteristics, specifically the importance of a non-judgemental patient-centred approach, 'resisting the righting reflex' and putting aside one's own agenda, as indicated in expert testimony 5.	Thank you. The guidance highlights the importance of taking a person-centred approach.
British Nutrition Foundation	Recommendation 17	21	In addition to monitoring outputs, behavioural outcomes and intervention fidelity, there should be explicit mention of the need to evaluate intervention acceptability and feasibility in the client population and in the delivery setting.	Thank you, we have amended the recommendation to include service user views.
British Society for Community Dentistry (BASCD)	General	1	This guidance should stipulate 'tobacco' and outline that is includes smoking and oral tobacco. The Smokeless Tobacco guidance should be referenced.	Thank you for your suggestion. The evidence reviewed for this guidance was on smoking only, therefore it would not be appropriate to use the term tobacco use.

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British Society for Community Dentistry (BASCD)	General	2	Other organisations should be laid out here such as Public Health England, Clinical Commissioning Groups and NHS England.	Thank you for your comment but we do not single out organisations in this section.
British Society for Community Dentistry (BASCD)	General ' Whose health'	4	Should mention or uses tobacco not just those who smoke.	Thank you for your suggestion. The evidence reviewed for this guidance was on smoking only.
British Society for Community Dentistry (BASCD)	General 'Recommendation 2'	7	Clarify who collects and collates data as at present this is unclear. Suggestion: any organisation who collects routine data should ensure this is available to commissioners and other parties.	Thank you for your comment. The recommendation states that it is providers who collect the data.
British Society for Community Dentistry (BASCD)	'Recommendation 3'	8	There is no mention of pilot or feasibility studies here and this is alluded to in section 3.45. It should be at the front end of the document on page 8.	Thank you. The recommendation has been amended to include pilots.
British Society for Community Dentistry (BASCD)	General 'Recommendation 4'	9	Suggest using the word 'ensure' rather than 'encourage' (line 1).	Thank you, this change has been made.
British Society for Community Dentistry (BASCD)	General 'Recommendation 7'	12	Linking in with expert partners such as PHE should be referenced here.	Thank you, partnership working is recommended elsewhere and we would not single out a specific organisation.
British Society for Community Dentistry (BASCD)	General 'Recommendation 7'	12	Also include those who work on oral health issues such as dental teams in the high intensity section as the links to oral cancer are well evidenced.	Thank you for your comment. Dental teams would be included under

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				service providers. We have not highlighted specific practitioners.
British Society for Community Dentistry (BASCD)	General 'Recommendation 8'	13	It should be acknowledged that some health professionals are only trained to deliver very brief intervention due to their capacity, it is not necessarily led by the patient's response to the intervention.	Thank you for this comment, practitioners are expected to only deliver what they have been trained to provide.
British Society for Community Dentistry (BASCD)	General 'Recommendation 13'	18	The following websites should be referenced: Alcohol: www.alcohollearningcentre.org.uk/elearning/iba/ MECC training: http://learning.nhslocal.nhs.uk/feature-list/training?page=1	Thank you for your comment. We can only recommend resources that the PDG have all looked at and agreed are appropriate.
British Society for Community Dentistry (BASCD)	General 'Recommendation 15'	19	MECC training should be referenced.	Thank you for your comment. MECC is not mentioned by name in the guidance. Please see implementation tools for training support, where it is referenced.
British Society for Community Dentistry (BASCD)	General Section 2	24	Cite behaviour and health research unit http://www.bhru.iph.cam.ac.uk/	Thank you for your suggestion. As there are no recommendations on choice architecture reference to BHRU in this section has not been added.
British Society for Community Dentistry (BASCD)	3.21	29	Although it is noted that interventions are not assessed beyond 6-12 weeks routinely it should be acknowledge that many professionals including the	Thank you. Please see the recommendation on

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			dental team have long-term contact on a regular basis with their patients and could therefore assess the impact of such interventions.	maintenance of change.
British Society for Community Dentistry (BASCD)	6 Glossary	35	Refer to the Alcohol Learning Centre	Thank you for your comment. We can only recommend resources that the PDG have all looked at and agreed are appropriate.
Cambridge Weight Plan	General		Cambridge Weight Plan (Cambridge) welcome the work done by NICE on behaviour change interventions and hope that the evidence base on effective interventions in this area will form part of the development of the forthcoming guidance on Managing overweight and obesity in adults – lifestyle weight management services.	Thank you for your comments Detailed guidance for weight management in adults and the components of interventions will be covered by the guidance you note.
Cambridge Weight Plan	Recommendation 5	9	Cambridge welcome this recommendation and endorse the idea of local weight management services helping to develop behaviour change interventions on diet and physical activity. Cambridge already work through a nationwide of 2500 local Consultants, who help individuals help themselves lose weight partly through a programme of physical activity called Cambridge Active. Given the local nature of the Consultant, he or she is able to take into account the social and cultural context in which participants live.	Thank you for your comments.

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Cambridge Weight Plan	Recommendation 9	14	No programme can be a success unless behaviour change interventions are specifically tailored to fit in with that programme, as with Cambridge programmes which are tailored to the needs of the individual participants. Our Consultants support individuals on Cambridge programmes all the way through the programme in order to help them lose weight and, crucially, maintain this weight loss.	Thank you for your comments.
Cambridge Weight Plan	Recommendation 10	15	Cambridge already uses behaviour change techniques in their programme, working to help individuals on the programme to set clear goals for weight loss and weight maintenance.	Thank you for this information.
Cambridge Weight Plan	Recommendation 11	16	Individual Consultants work extremely closely and on a one-to-one basis to help individuals lose weight and maintain this weight loss.	Thank you for this information.
Cambridge Weight Plan	Section 2	23	Cambridge are happy to work with NICE to help develop practical advice on which techniques should be used to tackle specific behaviours, which we feel is lacking from this guidance.	Thank you for your comment. It was decided that this guidance would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in more detail. Please see http://www.nice.org.uk/getinvolved/ for details of

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				how to get involved with NICE.
Cambridge Weight Plan	3.5	25	We welcome the PDG's discussion of the role of commercial companies in contributing to behaviour change and the potential contribution they could make to behaviour-change programmes. Again, Cambridge would be keen to work with NICE on developing an evidence-base on this. On a related issue, evidence also suggests that financial incentives, as one part of a multi-component weight management programme, can play a particularly effective role in tackling obesity. This is stated in the Government's own Healthy Weight, Healthy Lives strategy from 2008 (page 42). Weight management programmes not only demand a considerable commitment from participants but also offer a financial incentive to lose weight.	Thank you but we are unable to accept or review additional evidence at this stage.
Cambridge Weight Plan	3.18	28-29	As noted above, Cambridge would be happy to collaborate with NICE to ensure that behaviour change techniques in the area of diet are of high quality and properly assessed, provided that NICE ensure that commercially sensitive information is protected in some way.	Thank you
Cambridge Weight Plan	3.42	33	Cambridge note that NICE are not making any recommendations on the use of choice architecture interventions and would prefer to research this further. This is understandable but given that there is a considerable amount of evidence on the best way to tackle obesity, including using behaviour change techniques, Cambridge would have expected to see some practical recommendations made.	Thank you for your comment. It was decided that this guidance would not provide specific recommendations for a particular behaviour or behavioural outcome. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular topic in more detail.

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Cambridge Weight Plan	4.1	34	Given the extent of the obesity epidemic in the UK and the burden it creates on NHS resources, developing choice architecture interventions relating to diet and weight loss must be a priority.	The PDG did not feel that there was sufficient evidence in relation to health to warrant recommendations around choice architecture – however, it is included as a research recommendation.
Cambridge Weight Plan	4.1	34	Cambridge welcome the recommendations for research made by the PDG, on the effectiveness of choice architecture interventions in commercial settings and we look forward to further opportunities to provide evidence on the effectiveness of our interventions.	Thank you
Cardiff University	General		Whilst separate reviews and guidance documents for different approaches will be a useful tool when designing interventions, there is a need to recommend techniques and protocol for combining approaches. For example, methods of designing an intervention using the Social Ecological Model to integrate both an individual and community approach effectively, and the advantages of doing so, should be outlined (Stokols, 1996).	Thank you for your comment. Community and population approaches are out of scope for this guidance they will however subject to future guidance
Cardiff University	General		The behaviours covered are important areas, but other behaviours that have been neglected, such as drug use, also present major public health challenges. For example, one survey of second year university students in the UK showed that 60% of men and 55% of women reported using cannabis once or twice, whilst 20% reported regular use. Other illicit drugs were also	Thank you for your comment. Drug misuse is out of scope for this guidance.

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			used by 33% of the sample, with 46% of drug users starting at school age (Webb *et al*., 1996). Drug use can present huge public health problems, such as mental health issues (Moore *et al*., 2007; Patton *et al*., 2002). Therefore, related literature should be considered and methods of promoting related behaviour change addressed within the guidance.	
Cardiff University	General		Recommendations within this document are very siloed. Multiple risk behaviours should be taken into account within these recommendations in order to acknowledge that unhealthy behaviours do not occur in isolation and sometimes cluster together (Jackson *et al*., 2012). Therefore, this review should summarise existing evidence and address effective methods of intervening to tackle clustering of multiple risk behaviours.	Thank you for your comments There is a lack of evidence for effective interventions across multiple behaviours, as identified in 'gaps in the evidence'.
Cardiff University	General (health inequalities)		The role of behaviour change interventions in reducing health inequalities does not feature heavily within the document. Furthermore, when health inequalities are mentioned, the recommendations made are inconsistent. For example, recommendations are given to consider health equity where commissioning programmes, but no recommendation for evaluation to incorporate assessment of the inequality impact. The impact on health inequalities is an important issue which needs to be addressed, as individual level behaviour change interventions may have the potential to widen health inequalities (Whitehead *et al*., 2007; Michie *et al*., 2009). Therefore specific recommendations for those with a high risk of bad health, such as low income groups, could be a useful tool.	Thank you for your comment The PDG recognised that the evidence for effective interventions to reduce inequalities remains under developed – see research recommendations. This is also recognised explicitly in other NICE publications – see PHB4

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				inequalities where less than 1% of research spending can be identified to be targeted towards inequalities research. Addressing inequalities in evaluation has been added to the recommendation
Cardiff University	General (health inequalities)		There is a need to clarify how broad principles relate to practical outcomes. For example, recommendation 1 states that 'strategies and policy should aim to improve everyone's health. Ensure the content, scale and intensity of each intervention is proportionate to the level of social, economic or environmental disadvantage someone faces and the support they need'. It would be helpful to provide some practical suggestions of how to do this.	Thank you for your comment. The recommendation is about ensuring these factors are accounted for in planning but the practicalities would need to be decided on basis of local profiles.
Cardiff University	Recommendation 1	5	The main issue that needs to be addressed is how to consult with local communities to relate interventions to context (Israel *et al*., 2001). For example, community-based participatory research has been shown to increase the relevance, usefulness, quality and validity of research and create a partnership of diverse expertise, knowledge and skills (Israel *et al.,* 1998). Recommendations regarding this should build on joint strategic needs assessment, link to best practice and include links to relevant documents.	Thank you for this comment. This guidance is about providing guidance on behaviour change, it is unable to offer guidance on how to consult with local communities as that is out of scope and

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				evidence has been reviewed. However a number of pieces of guidance we have produced offers advice on working with local communities in particular PH9 community engagement, which is now referenced in the recommendation.
Cardiff University	Recommendation 2	6	The wording in the final bullet point for recommendation 2 is misleading as it seems as if short term and medium term interventions are being recommended. Changing the wording from 'as well as' to rather than just' more eloquently communicates that more funding should be allocated to long term interventions as opposed to the current trend of funding more short and medium term interventions.	Thank you for this comment. We have revised the recommendation to state 'Commission interventions that are proven to be effective at changing and maintaining behaviour change.'
Cardiff University	Recommendation 3	7	The review needs to acknowledge the complex nature of the definition of effectiveness. It is an oversimplification to describe any intervention or technique as effective. Individual studies may show that an intervention 'worked' (i.e. did more good than harm) in the time and place where it was delivered. But what works in one context (or with one population) will not in another (Campbell *et al*., 2007). Hence, guidance needs to consider how the policymaker (or other stakeholder) is to determine the relevance of the evidence base to their context (i.e. not 'what is the evidence that this works?',	Thank you for this comment. The guidance is designed to offer guidance and flexibility to allow for local shaping of services to the context

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			but 'what is the evidence that this will work if we use it here?').	within which it will be delivered. The recommendation has been amended to highlight the importance of pilots in evaluating intervention effectiveness under different circumstances from the original intervention.
Cardiff University	Recommendation 3	7	In evaluating behaviour change interventions, randomisation should be recommended wherever possible, in order to increase the likelihood that any difference observed between groups is due to the intervention, and not to confounding variables (Akobeng, 2005; Craig *et al*., 2008). Randomisation is usually, though not always feasible for individual-level interventions (Kemm, 2006). Where randomisation is not possible, robust quasi-experimental methods should be adopted to estimate effects (Bonell *et al*., 2011).	Thank you for this comment. Please note that this guidance is not intended as a guide on how to undertake research, and the recommendations do suggest that evaluations be appropriately designed and conducted. Please note that implementation tools that support this guidance include a Podcast on how to recognise and use good quality evidence in public health.
Cardiff University	Recommendation 4	8	This recommendation is essential to good practice. The advice relating to the provision of adequate training for staff involved in behaviour change interventions is particularly important. This advice could be enhanced through the addition of a recommendation for all staff to be research literate and by	Thank you for this comment Please note that this

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			including links to UKCRC centres or research advice services/infrastructure so that advice on evaluating interventions can be easily accessed.	guidance is not intended as a guide on how to undertake research.
Cardiff University	Recommendation 5	9	The link between this recommendation and recommendation 10 is unclear, and should be clarified as designing and selecting programme content is an integral part of planning an intervention.	Thank you for your comment. Please note that all the recommendations in the guidance should be looked at together rather than in isolation. Content is highlighted in the recommendation (final bullet point, sub-bullet 5 under intervention characteristics)
Cardiff University	Recommendation 6	10	Again, the link between this recommendation and recommendation 10 is unclear and should be clarified as designing behaviour change interventions and programmes also involves deciding upon appropriate programme content.	Please see response above.
Cardiff University	Recommendation 6	10	This recommendation requires more context and evidence-based advice. The questions answered could include; how intensive and how long should monitoring and evaluation be (Wiehe *et al*., 2004)? What methods should be used and should these methods change according to context (Kemm, 2006)? Evidence could be taken from systematic reviews, such as that from a review of school-based smoking prevention trials with a long-term follow-up which recommends the need to measure smoking at age 18 to predict adult smoking patterns (Wiehe *et al*., 2004).	Thank you for your comment. Please note this recommendation covers broad principles of what should be addressed. This guidance is not on how to undertake research.
Cardiff University	Recommendation 7	12	The references to 'all staff' with reference to the delivery of brief interventions are too broad and should be clarified. Also, recommendations should clearly	Thank you for this comment. This

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			define and distinguish between different types of 'very brief intervention' as this could range from signposting to conducting a short motivational interview, for which different staff will have different capabilities/resources (Roche & Freeman, 2004).	recommendation has been amended.
Cardiff University	Recommendation 7	12	There are ethical issues arising from recommending that all workers in contact with the general public should be delivering brief interventions. There could be harmful effects arising from this as patients could become reluctant to utilise services if they are constantly being approached about their health behaviour. If this were to be implemented, an organisational or systems approach would need to be employed in order to ensure communication between services and staff (Berg, 1999). Moreover, although there is a good evidence base for the efficacy of brief interventions for drug and alcohol use (Dunn *et al*., 2001; Vasilaki *et al*., 2006), professionals have been shown to be reluctant to employ these methods and brief interventions have been shown to have less success in practice (Roche & Freeman, 2004). Therefore, barriers to resistance from staff members, such as general practitioners would need to be tackled.	Thank you for your comment. The recommendation states only trained individuals should deliver interventions. We are not aware of evidence that providing brief interventions would deter people from using services. Recommendation 2 addresses organisational support.
Cardiff University	Recommendations 8 and 9	13 & 14	Tailoring is a contentious issue and caution should be taken when recommending this. Research shows that there is a fine line between adapting an intervention to context and violating its underlying theory. One study, which looked at the adaptation of behavioural interventions according to culture concludes that rigorous scientific evaluation and testing should be conducted before adapting or tailoring interventions or programmes so that programme efficacy and fidelity is maintained (Castro *et al*., 2004). Hawe *et al*. (2004) also recommend that interventions should be adapted according to context, but that the main steps in the behaviour change process should be standardised. Moreover, practical issues, such as a finite amount of resources may limit intervention intensity and the ability to tailor and, therefore, should be	Thank you for your comment. The recommendations in this guidance are in line with what you have said. We recommend that content of an intervention is clear (see recommendations earlier on) but that this includes taking people's situations, abilities, etc

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			addressed within the document.	into account (– e.g. in rec 6 on designing interventions: 'details on how to tailor the intervention to individual needs'); and the importance of intervention fidelity is highlighted in recommendation 16.
Cardiff University	Recommendation 10	15	This recommendation needs to be linked with the others in order to make the document more coherent. Moreover, the issue of fidelity needs to be addressed alongside recommendations for programme content. The importance of fidelity and methods for improving fidelity should be highlighted. Recommendations to increase fidelity included increasing the flexibility of interventions without compromising the mechanisms of change (Hawe *et al.,* 2004) and measuring fidelity within programmes (Dusenbury *et al*., 2003). Furthermore, Bellg *et al*. (2004) made recommendations to increase programme fidelity, which include the following; establishing procedures to monitor adherence, dose and intensity and potential barriers to implementation, adequately training providers and monitoring and updating training throughout the intervention.	Please note that all the recommendations in the guidance should be looked at together; It is a balancing act how much cross-referencing to other recommendations is made. We try and limit cross-referencing to where it is absolutely needed. This recommendation is specifically about behaviour change techniques, as such fidelity is not discussed here, but in recommendation 16.
Cardiff University	Recommendation 10	15	A wider range of recommendations should be addressed within this section due to the potential dangers associated with presenting a limited range of	Thank you for your comments. These

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			techniques, which may not be appropriate for all age groups/behaviours. The Medical Research Council framework for developing and evaluating complex interventions (Craig *et al*., 2008) highlights that only through close attention to causal mechanisms is it possible to develop effective interventions and apply them across settings and target populations. However, prescriptive, oversimplified recommendations of techniques should not refer to all behaviour change interventions unless there is strong evidence that all of these techniques work equally well for all of the specified behaviours and in all contexts (see comments relating to recommendation 3 regarding the need not to naively present intervention components as 'effective'). The meta-analyses which provide much of the basis for these recommendations did not incorporate all of the behaviours which form the focus of this document. For example, although goal setting has been established as a useful technique in physical activity and diet research (Shiltz *et al*., 2004), can this evidence be generalised to all health behaviours in all contexts?	techniques are highlighted as these are the ones for which there is good evidence of effectiveness. Please see considerations for PDG deliberations on this. It is also recommended 'Consider using other evidence-based behaviour change techniques that may also be effective.'
Cardiff University	Recommendation 10	15	Complex interventions, by definition, are intended to be greater than the sum of their parts. They include components which are intended to work *in synergy* to produce outcomes (Craig *et al*., 2008; Campbell *et al*., 2000). Hence, whether the identified techniques 'work' will be dependent on, among other things, what other activities they are combined with. This complexity is missing from the recommendations which could lead to an oversimplified approach to developing, implementing and evaluating complex interventions, which does not carefully consider the synergy between components (Campbell *et al*., 2000).	Thank you for your comment. We reference the MRC guidance on complex interventions within the recommendations so that the reader can access this level of detail, which the guidance cannot provide.
Cardiff University	Recommendation 11	15	More in depth information on behavioural maintenance is required within this section. Moreover, there is a mismatch between the recommendations and available evidence. For example, reviews of physical activity and dietary interventions have shown long-term monitoring and feedback to be effective	Thank you for your comment. It was decided that this guidance would not provide specific

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			methods of maintaining behaviour (Greaves *et al*., 2011), but such evidence is not consistently available for all health behaviours (Glasgow & Lichtenstein, 1987). Evidence reviews should be utilised to create behaviour-specific recommendations.	recommendations for a particular behaviour. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in more detail. Recommendations do not provide information – they are recommendations for what should be done, not the 'why' they should be done – this information is available in the Considerations and in the evidence statements.
Cardiff University	Recommendation 11	15	Individual techniques, such as 'action plans', have not been randomised within studies. Intervention studies tend to include clusters of commonly co-occurring, So it cannot be easily established that a single technique that will result in behavioural change. Therefore, precaution should be taken by recommending the use of these as part of a 'package' of intervention techniques. The wording should also be less prescriptive so as not to insinuate that these techniques *must* employed to achieve behaviour change. Replacing phrases like, 'make sure' with 'should consider' would achieve this.	Please see responses above. This recommendation is on maintenance of behaviour change and the PDG agreed there was evidence to support these techniques.
Cardiff University	Recommendation 17	21	The advice 'if possible randomise' should be added to the list under the heading, 'providers of existing programmes should work with researchers to	Please see responses above.

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			ensure they are rigorously evaluated''. This should then be supported by describing the relevance to the MRC framework, which states that randomisation should always be considered (Craig *et al*., 2008).	
Cardiff University	Recommendation 17	21	Recommendations for independent evaluation should also be linked to research infrastructure and this provides a great opportunity to embed the use of an evidence base when designing and evaluating interventions (Campbell *et al*., 2000). Moreover, recommendations should state that the impact of interventions on health inequalities needs to be built into evaluations. Macintyre (2003) advises that, in order to reduce health inequalities, the design of public health initiatives should include good quality evaluations of the impact on health inequalities within the target population.	Please see responses above. The evaluation recommendation now states that impact on health inequalities should be monitored.
Cardiff University	Recommendation 18	22	Recommendations for independent evaluation should also be linked to research infrastructure and this provides a great opportunity to embed the use of an evidence base when designing and evaluating interventions (Campbell *et al*., 2000). Moreover, recommendations should state that the impact of interventions on health inequalities needs to be built into evaluations. Macintyre (2003) advises that, in order to reduce health inequalities, the design of public health initiatives should include good quality evaluations of the impact on health inequalities within the target population.	Thank you. We assume this is about the recommendation on evaluation rather than national support? The evaluation recommendation now states that impact on health inequalities should be monitored.
Cardiff University	Recommendations for research	34	Due to the limited evidence available in these areas, recommendations for research should state the importance of focusing on a combination of approaches, sustainability and maintenance, broader routine data and longer-term follow-ups.	Thank you for your comment. This level of detail is not provided in recommendations for research and it is the responsibility of researchers to ensure

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				research is undertaken in an appropriate manner.
Child Accident Prevention Trust (CAPT)	General		The Child Accident Prevention Trust is the leading national charity working to reduce the number and severity of preventable accidents to children and young people. We work with a wide range of stakeholders and community-based partners to promote understanding and awareness of the often simple steps which can be taken by parents, carers, and many others to reduce the burden of unintentional injury which is the subject of separate NICE guidance.	Thank you.
Child Accident Prevention Trust (CAPT)	The following comments relate to Recommendations 7 and 9	12ff	We welcome the explicit role in achieving behaviour change which is identified in the Draft Guidance for the community and voluntary sector. However it would be good to see some specific examples of how behaviour change principles and delivery can impact specifically on the health, safety and wellbeing of children. The following observations may therefore be helpful. For many years, CAPT has promoted accident prevention messages at local level, both through our flagship Child Safety Week community education campaign, and through year round activity which sustains and supports this work through direct links, downloadable resources, mentoring and training for practitioners.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Child Accident Prevention Trust (CAPT)			Our experience confirms the vital importance of using every opportunity to share child safety knowledge and understanding and to 'make every contact count'. This can be done in the context of a wide range of other interventions, contacts and outreach programmes where families may be more receptive to positive support and a 'strengths-based' approach to safety advice and information. The Family Nurse Partnership is a good, evidence-based example of how behaviour change for child safety and wellbeing can be achieved through such	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			an approach. Given the steep inequalities gradient for childhood injury, this is a particularly important aspect of any local action to tackle health inequalities.	
Child Accident Prevention Trust (CAPT)			In our view, it is vital that these behaviour change opportunities are reinforced and underpinned by an awareness of the links between accidents and child development. Training should therefore be an integral part of the Delivery roles and responsibilities of NHS and public health professionals, VCS providers and all staff who have contact with families and the wider public.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Child Accident Prevention Trust (CAPT)			We agree that 'becoming a parent' is one of the key times when people are open to change, and we believe that this willingness to learn may extend to wider family and neighbour connections. The role of grandparents, for example, is an increasingly important aspect of informal childcare in many families and communities.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Child Accident Prevention Trust (CAPT)			Our experience in running Child Safety Week has highlighted some particularly useful approaches to support and encourage behaviour change for child safety. These include: • **Making a pledge of time or a commitment to act** – Some studies have shown that explicitly writing down intentions may increase the likelihood that the commitment will be kept *(see also Cabinet Office Behavioural Insights Team, Behavioural Bulletin, Issue 3)*	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Child Accident Prevention Trust (CAPT)			• **Taking simple, small steps** to make the changes which can actually have a major impact on the safety and wellbeing of children.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				guidance.
Child Accident Prevention Trust (CAPT)			• **Recognising that the pressures of time** and everyday stress can make parental supervision less effective. This characteristic, where there may be some elements of forewarning, has been described as 'neglectful supervision' *(see 'Neglect and Serious Case Reviews', University of East Anglia and NSPCC, Jan 2013)*	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Child Accident Prevention Trust (CAPT)			• **Using straightforward, picture based communication** to achieve 'safety without the small print'. The challenges in many communities of poor literacy and multiple parental languages make it essential that basic child safety information is easy to access and understand. CAPT's 'picture of safety' resources are a proven way of achieving this in a user-friendly way. They also support practitioners in their task of getting alongside and engaging with families for whom written materials can be a barrier to behaviour change.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Child Accident Prevention Trust (CAPT)			• **Working with children's centres** and other community hubs to ensure that safety information is attractively displayed, and is presented in a helpful, informative and even fun approach. This helps to engage parents and carers, but it can also be a welcoming way to involve community partners who have important messages to share. This kind of simple but effective learning environment has been described by Ofsted as 'the third teacher'. (See Ofsted Good Practice Example for early Years – 'Linger and learn – welcoming and engaging parents and carers' Sept 2012)	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
COPE Occupational Health and Ergonomic Services Ltd	General		Within the expert testimony it is stated: "In Europe, 33% of the entire disease burden is thought to be caused	Thank you but your comments do not appear to relate to the draft

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			the following reducible population risk factors: tobacco consumption, excessive alcohol use, a high blood pressure high LDL cholesterol levels, high Body Mass Index and high blood sugar levels." When objective measures are utilised to measure cardio respiratory fitness, however, the leading reducible population risk factor is Cardio Respiratory Fitness (CRF) - example reference: Blair SN. Br J Sports Med 2009; 43:1-2. The use of effective strategies and tactics to create behavioural change to improve CRF within, in particular, the lower socio-economic group will have the biggest impact on the incidence and prevalence of non communicable disease in the general population	behaviour change guidance.
Coventry University	Recommendation 2	6	'They should also include strategies to address relapse and recognise that this is common.' Should perhaps also include that relapse can contribute to the overall behaviour change process.	Thank you for your comment, evidence on this was not reviewed.
Coventry University	Recommendation 2	7	It is unclear what indicators would be considered so as to constitute an intervention that has been 'proven to be effective'	Please note that this guidance is not intended as a guide on how to undertake research. Please note that implementation tools that support this guidance include a Podcast on how to recognise and use good quality evidence in public health.
Coventry University	Recommendation 3	7	The advice given is to: 'Find out whether existing behaviour-change interventions and programmes	Thank you for your comment,

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			are effective and cost effective, are using proven techniques and are applying evidence-based principles. (See Behaviour change at population, community and individual levels, NICE public health guidance 6).' However, Public Health Guidance 6 largely refers to behaviour change at the theoretical or model level rather than a skill or (how to) level. Whist it is recognised that there is variance in the theoretical underpinnings employed to behaviour change interventions, perhaps specific guidance should be given regarding the skills required such as the principals and methods of motivational interviewing for example. This would assist with clarity and also treatment fidelity which is critical to behaviour change interventions.	recommendations on behaviour change techniques and practitioner skills for which there was evidence have been made.
Coventry University	Recommendation 3	8	It is unclear what would deem an intervention as not effective and therefore result in disinvestment. Given that relapse forms a critical part of behaviour change in the longer-term how would this be monitored and factored into considerations of efficacy?	Please note that this guidance is not intended as a guide on how to undertake research.
Coventry University	Recommendation 4	8	The commentary regarding behaviour change support for staff should include opportunities to develop their behaviour change skills post training. Training staff in behaviour change skills without adequate follow-up support that is integral to the organisational culture has been shown to be consistently ineffective.	Thank you. The guidance has been amended to address this e.g. in recommendation 2.
Coventry University	Recommendation 4	9	It is advised that staff 'should also be offered ongoing professional development on behaviour-change theories and methods.' Perhaps the term skills should be included here.	Thank you. Skills have been added.
Coventry University	Recommendation 6	11	A list of recommendations are provided with respect to the design of programmes. Specific reference to follow-up supervision/training and creating an organisational culture that supports the ongoing skill development of behaviour change techniques should be included.	Thank you for your comment. Please note these issues are covered in other recommendations, e.g.

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				on organisational support (rec 2).
Coventry University	Recommendation 6	11	The use of a behaviour change taxonomy is suggested. Whilst at the programme level, these can be helpful for intervention replication; for practitioner skill development, the use of a taxonomy can often hinder progress by shifting the focus away from simple yet effective skill use to a misunderstanding that practitioners should be proficient in all skills identified within the taxonomy used.	Thank you for your comment. The recommendation provides using a taxonomy as an example, hence it does not limit practitioners to using these.
Coventry University	Recommendation 7	12	'a very brief intervention' and also 'brief intervention' are referred to. However the definition provided for each refers to providing advice and signposting which the evidence-base has consistently shown to be ineffective for initiating and maintaining behaviour change. There is no reference to person-centred approaches which are deemed to be much more effective. The 'high-intensity intervention' description is vague with no reference to the specific skills required to work with such individuals.	Thank you for your comment. For 'brief intervention' the glossary clearly states it involves 'verbal discussion, negotiation or encouragement, with or without written or other support or follow-up.' And includes offering a referral, not signposting. For the very brief intervention this is the first step in the behaviour change process and one that can be delivered by a broad range of individuals. The recommendations

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				highlight person-centred approach. The glossary is about providing a definition, it is not intended as a comprehensive guide to all that an intervention entails. Recommendations on training highlight the skills practitioners need.
Coventry University	Recommendation 9	14	Some of the recommendations listed under 'what action should they take' are more consistent with an advising or directive style of attempting to support people to undertake change which has consistently shown to be ineffective. Whilst the current recommendations do not advocate a particular method of behaviour change as such, there is a real danger that by not doing so, some of the current guidance could be interpreted as being delivered in a directive manner which again is consistently ineffective. This is especially true of the following recommendation: 'discuss what the likely impact on their health will be if they do make changes.'	Thank you. The guidance highlights the importance of taking a person-centred approach. The highlighted recommendation has been amended.
Coventry University	Recommendation 10	15	There is no reference to exploring whether the person actually wants to change their health behaviour(s). It is difficult to understand how these recommendations could be met without the integration of a person-centred behaviour change technique such as motivational interviewing, for example.	This recommendation is about specific techniques. Goals and planning cannot be done without the person wanting to change their behaviour as it is a co-operative process between the client and

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				practitioner. Motivational interviewing is not a specific technique but made up of several behaviour change techniques (BCT as defined in this guidance - see glossary). The importance of person-centred approach is made in the guidance. Please note that all the recommendations in the guidance should be looked at together rather than in isolation; and Recommendations are written in a way to avoid repeating information in other recommendations.
Coventry University	Recommendation 12	16	It is difficult to understand why the recommended training does not make specific reference to an evidence-based behaviour change skill. The use of brief interventions in the manner described are ineffective. Training should be provided that equips staff with the ability to explore whether individuals want to make a health-behaviour change and supports them in a person-centred manner to undertake any changes that they may be ready for. Advising and directing is ineffective unless in the few incidences whereby an individual is highly motivated to undertake change. However, in this instance, change is	Thank you for your comment. The recommendation refers to later recommendations on training competencies which addresses these issues.

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			usually initiated without the need for behaviour change health services. Again, the lack of specific reference to the method of behaviour change skill/counselling to be used may cause training fidelity problems and opportunities for cross-comparison across interventions problematic.	
Coventry University	Recommendation 12	17	Again, there is little clarity regarding the 'how to' of delivery – the specific method. The reference to' very brief intervention' in the manner defined within the document is again problematic and not reflective of the evidence-base.	Thank you for your comment. This recommendation is about commissioning. Please see later recommendations on training. There are varying views of what constitutes different levels of intervention. This definition was the one agreed upon by the PDG.
Coventry University	Recommendation 14		It is unclear what the specific behaviour change techniques are or how these will be conveyed to practitioners during appropriate training	Thank you for your comment. This recommendation covers general principles of training. The guidance covers behaviour change techniques elsewhere (e.g. need for manuals to provide details of BCTs used). Please note that all the recommendations in the guidance should

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				be looked at together rather than in isolation; and Recommendations are written in a way to avoid repeating information already in other recommendations.
Coventry University	Recommendation 15	19	Some of the skills recommended are not congruent to the most important skill listed of developing rapport and empathy. For example, practitioners will need to be advised on how they may assess people's behaviour using validated tools and communicate relevant health information whilst also adopting a reflective listening approach and enhancing empathy. Such skills are possible but perhaps the necessity to develop empathy and rapport initially needs to be explicit within the recommendation. The recommendations for specific skill development are extremely limited and do not reflect those skills required from even the most basic behaviour change counselling skills (such as motivational intervening and solution focussed therapy, for example). I would strongly recommend that the specific skills listed reflect the evidence-base in tjis respect. In the document's current format it is very difficult to understand the how to recommendation of behaviour change delivery. Adopting a clear evidence-based approach in this way would assist greatly with clarity, consistency and training/treatment fidelity.	Thank you for your comments. Please note that empathy and rapport are explicitly listed in the recommendations. The skills highlighted in this recommendation are the ones for which there is good evidence of effectiveness. Motivational interviewing comprises a set of skills including reflective listening. The evidence base for these specific skills is highlighted in The evidence section which links recommendations to the evidence.
Coventry University	Recommendation 15	20	The word counselling is used which makes it difficult to understand why an evidence-based counselling technique such as MI is not recommended	Please see response above. Please note,

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			specifically throughout.	counselling is no longer referred to.
Coventry University	Recommendation 15	20	Perhaps the practitioner should also be invited to identify their own targets for skill development?	Thank you, the recommendation has been amended to reflect your suggestion.
Coventry University	Recommendation 17	22	The importance of 'intervention fidelity' should be stressed with respect to how closely the method of delivery reflects those techniques that have been agreed by the commissioner and delivered by a suitable behaviour change practitioner/trainer. The issue of treatment fidelity in this specific respect is critical to behaviour change practice.	Thank you for your comment. Please note that there is a glossary definition for intervention fidelity.
Coventry University	General		The lack of specific guidance regarding evidence-based person-centred techniques that avoid simply directing or advising someone how they should undertake health-behaviour changes and instead support self-efficacy and autonomy is evident throughout the document save to a single reference regarding 'group counselling' which would imply the use of the aforementioned person-centred techniques. There is a critical opportunity to move away from the traditional and ineffective information giving and directing approach to health-behaviour change and to introduce more effective person-centred methods however, regretfully there is no reference to this.	Thank you for your comment. We agree that a person centred approach is important and this has been reflected in the re-drafting of the guidance.
Department of Health	General		**I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you.
Department of Nutrition & Dietetics	Recommendation 10	15	The main elements of behaviour change techniques discussed include goals and planning, feedback and monitoring and social support. These are all techniques that are important to use when someone has decided they are ready to make a behavioural change. In practice however, equal importance should be given to techniques to facilitate and guide individuals towards reaching a stage where they are ready to make those changes through motivational interviewing for example as often individuals have not yet reached that stage when they come into contact with health professionals and	Thank you for your comments. These techniques are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific

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			to push them towards goal setting before they are ready would undermine their ability to successfully make changes *We agree with all above engagement and evoking are the first steps to aid change before goal setting is reached.*	techniques is highlighted in 'a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence and is discussed in the considerations. Please see the glossary definition of goals and planning – it is not about pushing people to do anything, it is about working collaboratively to set goals. Tailoring and adapting to people's needs is highlighted in recommendation 8 and taking a person-centred approach is highlighted as key.
Department of Nutrition & Dietetics	Recommendation 15	19/20	Again only one line included on reflective listening and empathy as a skill needed by practitioners. This should be given more importance alongside communication techniques such as the use of open questions, affirmations, reflections and summaries as again if practitioners rush to goal setting before an individual has had an opportunity to explore their thoughts about change, the pros and cons etc, any attempts to make sustainable changes are less likely to be successful. *Assess behaviour using an assessment tool: assessment forms can hinder a consultation and people can be at many stages through out a consultation.*	Thank you for your comments. Recommendations are written to be as succinct as possible. Assessing a behaviour refers to the behaviour the person is aiming to change (e.g. smoking), it does not refer to

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				assessing 'stages of change' or readiness to change. Wording has changed to make this clear.
Department of Nutrition & Dietetics	Recommendation 4	9	Recommends ongoing professional development on behaviour change theories and methods – need to include practical skills to deliver behavioural interventions alongside this	Thank you. 'Skills' has been added to the recommendation.
Department of Nutrition & Dietetics	Recommendation 16	20	*Use of transcripts: this takes a huge amount of skill to code transcripts ?? who would be able to do this (this is highlighted on pg 32/33)*	Thank you for your comment. The recommendation states that this is the 'ideal' way to undertake an evaluation.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		We welcome this timely guidance. We note that it is limited to those aged 16 years and above. We recognise and accept the rationale for this, particularly in relation to behaviours illegal below this age. However, we are concerned that limiting it to those aged 16 years and above does not recognise the possibility that harmful behaviours may become embedded over time, and that many harmful habits particularly poor diet and low levels of physical activity, may already be well established by then. Some of these may also impact upon others e.g. in young girls smoking may be used as a method of controlling body weight. We are concerned that by limiting the guidance to those aged 16 years and above, the importance of early intervention e.g. in families with young children, may be missed thus inadvertently negatively impacting upon other NICE guidance (such as Managing obesity and overweight among children and young people), in which early intervention is recommended.	Thank you for your comment.It is outside the scope of this guidance to discuss what should be delivered to under 16s. This will be the subject of future guidance.
Dietitians in Obesity Management UK (domUK); a specialist group of the British	General		In relation to the point above, given the complexity of working with families, we would like this to be emphasised at the start of the document, either in a separate section or consideration given to the possibility of developing	We do not make recommendations to ourselves on future

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Dietetic Association			separate guidance for it.	guidance.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		The term 'techniques' is used throughout the document and is not in line with the spirit of a behavioural approach to working with people. It conveys the idea of something, perhaps covert or manipulative, which is done by healthcare professionals to others, rather than working in a behavioural way to facilitate change. We would prefer that words such as 'tools', 'strategies' or 'approaches' be used instead of 'techniques'.	Thank you for your comment. We have endeavoured throughout the document to use the terms that are found within the literature and likely to be recognised by the target audiences for this guidance. In this case 'techniques' is a term used very specifically in key evidence considered by our PDG, and the way the term is used in the guidance reflects this evidence. Furthermore, NICE has very clear editorial policy that restricts what terms we may use in guidance documents. – and 'techniques' is a simple, neutral term. 'Tools' may also be used in both negative and positive ways, as may 'approaches'. We define

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				behaviour change techniques in the guidance glossary so that readers are very clear how the word is used.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		This draft fails to address the importance of attitudes, values and beliefs of the practitioner and the patient/client.	Thank you for your comment. We agree these are important issues and there are several recommendations covering these, such as recommendation 2 on organisational support, recommendation 8 on meeting individual needs and recommendation 12 on training.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		This draft fails to recognise the importance of the helping relationship, which itself is greatly influenced by the core values of practitioners (empathy, genuineness, acceptance & compassion).	Please see comment above.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		The central importance of good communication skills for building rapport, establishing a helping relationship & influencing & motivating change is not recognised throughout. Although these skills are briefly mentioned, we would like them to be emphasised throughout this document as fundamental to effecting behaviour change.	Rapport and relationship building are specified in Rec 12
Dietitians in Obesity	General		The behaviours mentioned throughout are all different (such as alcohol	Thank you, this view is

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Management UK (domUK); a specialist group of the British Dietetic Association			consumption, physical activity, diet, sexual behaviours) so the application of core approaches to each will be very different. We feel it is important to recognise that a practitioner skilled in one area will not necessarily be skilled in others. Although the approaches to each may be similar, their application will be very different.	reflected in the recommendations, for example, please see Recommendation 11.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		We feel that there is need for an additional recommendation, that of the role of healthcare professionals advocating for changes to unhealthy environments. This would support recommendation 11 (Maintenance of behaviour change), particularly in relation to ensuring that the individual has made the physical (environmental) changes needed.	Thank you for your comment. Please note that community and population level interventions that were not choice architecture interventions are out of scope for this guidance: you may be interested in NICE public health guidance PH6 for recommendations on community and population based approaches to behaviour change.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		Whilst the Considerations section (in particular sections 3.23-3.26) makes clear that behaviour change is not simply about specific techniques (tools), this is not generally reflected in the recommendations. In particular the focus upon development of manuals implies that the techniques (tools) alone are sufficient to bring about behaviour change. We feel that there needs to be clarity throughout the document that the personal qualities of the facilitator and the development of a strong helping relationship are essential to facilitating change; that the tools alone are not sufficient.	Thank you for your comment. This guidance deals with a range of individual level behaviour change approaches, delivered by a range of professionals. We recognise that the issues you raise may be

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				important in many of the interventions covered by the umbrella term 'individual approaches' – however, they may be less relevant to the brief and very brief interventions discussed where there is less opportunity to, say, build rapport. Also, please bear in mind that this guidance does not cover clinical interventions, where more consideration may be given to patient / clinician relationship. Taking into account the range of interventions addressed in the recommendations and the limits of our scope, we do not agree that further amendment is required as the recommendations already address them in relevant areas.
Dietitians in Obesity Management UK (domUK); a	Recommendation 2	7	To the point about gathering of routine data, we would like to see diet and physical activity added to examples of such behaviours.	Thank you for your comment. Examples are

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specialist group of the British Dietetic Association	Commissioning behaviour-change programmes: principles. What action should they take?			not meant to be an exhaustive list and are only illustrative, physical activity and diet are used as examples elsewhere.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 2 Commissioning behaviour-change programmes: principles. What action should they take?	7	We agree that relapse is important and needs to be addressed from the outset of any intervention.	Thank you for your comment.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 2 Commissioning behaviour-change programmes: principles. What action should they take?	7	We agree that programmes need to use evidence-based principles & approaches.	Thank you for your comment.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 2 Commissioning behaviour-change	7	In relation to evidence of effectiveness over different time spans, we would like 'in that setting' added to this point.	Thank you for your comment. We are not limiting the recommendation to interventions only proven

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	programmes: principles. What action should they take?			to be effective in a particular setting but we highlight the need to undertake pilots when effectiveness of an intervention for a particular setting, population, etc is not known.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 3 commissioning behaviour-change programmes: quality & effectiveness. What action should they take?	7	We would like to see 'staff' added to time and funds allocated for independent evaluation.	Thank you, we have made this change.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 3 commissioning behaviour-change programmes: quality & effectiveness. What action should they	8	To the penultimate point (Only commission an intervention...) we would like to see ..'and is based upon sound principles' added. We would like further clarification of this point.	Thank you for your comment. Issues concerning study design and evaluation are in other recommendations.

Public Health Guidance

Behaviour Change (partial update of PH6) Consultation on the Draft Guidance
Stakeholder Comments Table

5th June 2013 – 31st July 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

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	take?			
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 3 commissioning behaviour-change programmes: quality & effectiveness. What action should they take?	8	Clear criteria will need to be in place to measure effectiveness of interventions in order that a lack of effect can be demonstrated.	Thank you for your comment. Please note that this guidance is not intended as a guide on how to undertake research. Implementation tools that support this guidance include a Podcast on how to recognise and use good quality evidence in public health.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 4 Providing organisational support for behaviour-change interventions & programmes. What action should they take?	8	With regard to the first point, we agree that behaviour change services should be in place but would like clarification of how and if these would differ from current provision (e.g. specialist smoking/alcohol/drug services).	This would be for local decision makers to decide, based on appropriate needs assessment.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 4 Providing organisational support for behaviour-	8	We agree with the second point but would like the wording changed from 'make' staff aware to 'ensure staff are aware'.	Thank you. This change has been made.

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	change interventions & programmes. What action should they take?			
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 4 Providing organisational support for behaviour-change interventions & programmes. What action should they take?	9	We agree that staff should be encouraged to receive behaviour-change training related to their roles and responsibilities; indeed it may be mandatory, depending on the roles and responsibilities involved. However we would like 'and practices' added to 'behaviour-change theories & methods'.	Thank you for your comment. "Skills" has been added to this recommendation rather than "practices".
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 4 Providing organisational support for behaviour-change interventions & programmes. What action should they take?	9	A fundamental component of effective behaviour change is good communication skills. We would like an additional point made about the need for all staff to receive mandatory communication skills training, including small group practice of these skills. We would like to see all training evaluated with regard to outcomes i.e. do staff undergoing communication skills training communicate more effectively as a result of such training?	We cover the detail of what practitioner training should cover in later recommendations
Dietitians in Obesity Management UK (domUK); a	Recommendation 5 Planning	9	We agree that duplication should be avoided. We feel that where it is proposed that existing services are replicated, clear justification should be	Thank you for your comment.

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specialist group of the British Dietetic Association	behaviour-change interventions & programmes		provided.	
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 5 Planning behaviour-change interventions & programmes	10	We agree with all points under 'take into account'.	Thank you.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 6 Designing behaviour-change interventions & programmes. What action should they take?	11	Under the third point, whilst we recognise the importance of clear descriptions of tools and approaches used, it is not necessarily the case that description of techniques will result in the replication of the component or indeed that change will be effected as a result. This relates to our third General point. There is no recognition here of the context in which the techniques (tools) are used, the personal qualities of the facilitator or the helping relationship which needs to be in place to facilitate change. A manual will not equip the reader with the skills required to carry out an effective intervention, and in our view manuals should **ONLY** accompany training and ongoing supervision. We also have concerns about important related issues such as copyright and intellectual property, which are often ignored in practice.	Thank you for your comment. Please note that this recommendation states 'provide details of the training needed (including learning outcomes) for practitioners' and other recommendations make clear the importance of personal qualities of providers (e.g. see rec 2 on organisational support and rec 12 on training). Recommendation 6 has been amended to highlight that copyright

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				details should be added to manuals.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 7 Delivery: roles and responsibilities. What action should they take?	12	With relation to the first point, we are not clear why this is included as it is not necessarily the case that all patients will wish to discuss their health behaviour with all staff (regardless of how the staff themselves may feel about such interventions, and how they fit with their roles & responsibilities).	Thank you for your comment. The guidance states clearly that a person centred approach should be taken, therefore if someone does not wish to discuss their behaviour a trained practitioner should respond appropriately to this view.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 7 Delivery: roles and responsibilities. What action should they take?	12	With relation to the last point, we feel that all staff need to know what **not** to do in order to avoid giving misguided unwanted advice, however well meaning. We feel that emphasis by front line staff should be given to the patient experience instead.	Thank you for your comment. Training should address 'do nots'.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 7 Delivery: roles and responsibilities. What action should they take?	12	With relation to very brief, brief, extended brief as well as high-intensity interventions, we would like to see the need for robust independent evaluation explicitly stated even for those very brief interventions. The principle of 'First do no harm' should be adhered to by all staff in contact with the general public.	Thank you for your comment. This recommendation does not cover evaluation (see recommendation 16). Basic training should address not harming. The recommendation is

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				specifically about what should be delivered in relation to behaviour change and cannot cover all aspects of training.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 7 Delivery: roles and responsibilities. What action should they take?	12	With relation to the point about high-intensity interventions, we suggest that those with a BMI more than 40 may need additional assessment and specialist help (for the possibility of disordered eating for example)	Thank you for your comment.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 7 Delivery: roles and responsibilities. What action should they take?	13	We would like 'obesity' and 'morbid obesity' added to examples of serious medical conditions.	The examples are not intended to be exhaustive.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 8 Delivery: client assessment. What action should they take?	13	In the spirit of a behavioural collaborative approach, we would like to see 'assess' replaced with 'explore' on each line (points 1, 2 and 3).	Thank you for your comment. We understand the point you are making, however the term 'explore' is quite nebulous – what exactly would this entail? Are you suggesting this applies to the range of interventions covered by

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				this guidance? Terminology was discussed and agreed by the PDG, who drew upon the evidence and on their own considerable expertise. Furthermore, all NICE guidance goes through an editing process to ensure guidance is written in as plain English as possible to ensure it is clear to a wide audience. The guidance highlights the need to take a person-centred approach.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 8 Delivery: client assessment. What action should they take?	14	With relation to the final point, we would suggest that behaviour change practitioners may not necessarily be trained or qualified to carry out all assessments, for example ensuring that the level and type of physical activity recommendation relates to the state of physical health of an individual.	This is only an example and has been updated to make this clear.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 9 Delivery: meeting individual need. What action	14	To the penultimate point, we would like the addition of tailoring of support to maintain the changes on a daily basis - i.e. not only tailoring an intervention with relation to socioeconomic status, age, gender, culture, ethnicity and so on, but also tailoring the long term support needed to maintain these changes.	Thank you for your comment. We think that ensuring people 'are helped to develop routines that support the

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	should they take?			new behaviour (note that small, manageable changes to daily routine are most likely to be maintained). (see recommendation 10).' Covers the issues you raise.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 9 Delivery: meeting individual need. What action should they take?	14	We agree with the final point that support should be given but it is not clear **how** this should be given.	Please see recommendation 10 for the details of how this can be done.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 9 Delivery: meeting individual need. What action should they take?	14/15	We would like to see an additional point made about developing longer term coping skills in individuals, since it is recognised that the behaviours needed to change behaviours are not necessarily the same as the behaviours needed to sustain these changes.	Thank you for your comment. Maintenance of behaviour change is discussed in recommendation 10.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 10 Behaviour-change techniques	15	We would like to see this changed to 'Behaviour-change tools or approaches' instead of' techniques'	Thank you for your comment, but this recommendation is about techniques – please see our earlier response regarding terminology.
Dietitians in Obesity	Recommendatio	15	We feel that there are some important missing steps in point 1, which moves	Recommendation 8 is

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Management UK (domUK); a specialist group of the British Dietetic Association	n 10 Behaviour-change techniques		straight from assessment to goal-setting. The essential exploration and choosing of options need to be recognised. In addition we would like to see 'techniques' replaced by 'tools/approaches'.	about assessment and meeting individuals' needs within an intervention – i.e. the recommendations are not moving straight from assessment to techniques. This recommendation is about techniques, not tools or approaches – please see our earlier response. You may also find the systematic evidence reviews that support the guidance useful for further information on the use of the term 'behaviour change techniques' in the scientific literature – these will be published alongside the guidance on the NICE website.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 10 Behaviour-change techniques	15	Under Social support, the skill of enlisting help and support is one that needs to be developed in the patient with the help of the healthcare practitioner. We would like the wording here to reflect this important distinction.	Please see the glossary for details of social support and how the term is used in the guidance.

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Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 11 Maintenance of behaviour change	16	Instead of 'ensure that the person' we would like 'encourage the person' to reflect the fact that patients are developing these skills.	Thank you for your comment but we do not think that making this change would result in the shift in emphasis that you suggest. 'encourage' would indicate this is optional but the PDG are recommending that action plans should definitely be in place.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 13 General health and social care training: including behaviour-change within relevant curricula. What action should they take?	17/18	We welcome the recommendation to embed behaviour-change within curricula and in particular the emphasis upon delivery techniques and skills as well as knowledge. We feel strongly that academic knowledge is not necessarily the same as effective practice and demonstration of skills on an ongoing basis is key.	Thank you for your comment.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 15 Training for behaviour-change practitioners: the detail. What	19	We strongly agree that competencies should be demonstrated.	Thank you for your comment

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	action should they take?			
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 15 Training for behaviour-change practitioners: the detail. What action should they take?	19	To the second point (Ensure practitioners understand:) we would like to see 'the importance of developing a helping relationship' added.	Thank you for your suggestion but 'rapport and relationship-building' are specifically listed in the recommendation.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 15 Training for behaviour-change practitioners: the detail. What action should they take?	19	We would like to see an additional point added, about the need for ongoing support for behaviour-change practitioners.	Thank you for your comment. On-going support is highlighted in recommendation 2.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 15 Training for behaviour-change practitioners: the detail. What action should they take?	20	To the penultimate point we would suggest that 'relapse prevention' is changed to 'relapse management' to reflect that fact that relapse is very likely to occur as part of the change process.	Thank you. This change has been made.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 15 Training for behaviour-change	20	To the final point we would like to see 'group facilitation skills' added, and would consider that to be essential training for all those managing groups. We also feel that competencies in managing groups are essential to demonstrate.	Thank you for your comment but we think 'group facilitation skills' is already covered by the

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	practitioners: the detail. What action should they take?			wording in the final point. All NICE guidance goes through an editing process to ensure guidance is written in as plain English as possible to ensure it is clear to a wide audience.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Recommendation 15 Training for behaviour-change practitioners: the detail. What action should they take?	20	Mentors should also demonstrate competencies.	Thank you for your comment. The requirements for mentors to be trained is in recommendation 2.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	2. Public health need & practice	23	We disagree that there is a dearth of evidence for what works in weight management. Many large and long term trials have demonstrated that lifestyle change brings about weight loss (e.g. Look AHEAD, DPP & others). However the difficulty lies in ensuring that practitioners are skilled and competent facilitators of change. We feel it is vital that commissioners recognise that weight management is a specialist area of practice requiring specialist knowledge, skills & competencies.	Thank you for your comment but we cannot see where we specifically suggest there is a dearth of evidence for what works in weight management.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	3.8	26	We agree with this point.	Thank you
Dietitians in Obesity Management UK (domUK); a	3.2	29	We agree with this point.	Thank you

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specialist group of the British Dietetic Association				
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	3.23	29	We agree with this point.	Thank you
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Social support	39	Enlisting appropriate social support is a skill and should be recognised as such.	Social support has been described as a technique used in interventions, as such anyone employing it is, as set out in the guidance, expected to be appropriately trained.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Very brief intervention	39	Asking permission before giving advice is essential.	Thank you. The guidance does highlight the need to take a person-centred approach in delivering all interventions. Training appropriate to the type of intervention should also incorporate the issue of permission if relevant.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Motivational interviewing	52	Motivation is not the same as persuasion and should not be described as such.	Thank you for your comment. This appears to be in relation to the wording in evidence statement 1.7. Please

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				note that although motivational interviewing may not involve persuasion as the term is commonly defined, the definition of the Intervention Function "Persuasion" does not carry the same connotations. As an Intervention Function it is defined as: "Using communication to induce positive or negative feelings, or to stimulate action". The example provided for this is "Using imagery to motivate increases in physical activity". Based on this definition it was the intervention function which best fit the concept of motivational interviewing as described in evidence for the review. The evidence statement

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				has been reworded as follows to: "The content of motivational interviewing was often described in only limited detail in the guidance and evidence tables. Based on the detail provided it best matched Intervention Function 2 Persuasion (defined as "Using communication to induce positive or negative feelings, or to stimulate action")."
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Evidence statement 3.3.3	74	We agree with this important point.	Thank you
HEART UK	General	1.2.2 and elsewhere	The use of the term Mediterranean diet is becoming increasing blurred. The description used in the text is at best misleading The characterisation of a Mediterranean diet as 'more bread, fruit and vegetables and fish, and less meat; should better indicate the level of intake and perhaps specify wholemeal bread	Thank you for your comment, however we do not use this term in the guidance.
HEART UK	General		It is noted that detailed recommendation on statin therapy have been moved. It is not clear to me how this will be helpful for the integrated management by health professionals.	Thank you for your comment, however this is not covered in this guidance.

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KasTech Ltd	General	12	Would like clear definitions for high, medium and low-intensity interventions in definition section	The terminology used in the guidance to describe interventions of different intensity is provided in the glossary.
KasTech Ltd	General	37	Would like clear definitions for very brief, extended brief, etc. interventions	Please see response above
KasTech Ltd	Recommendation 11	16	Using the word **ensure** is not practical or realistic for many providers – they could help the person **explore** or **identify** action plans, social support, etc.	Thank you for your comment. Wording has been changed to highlight that practitioners should ensure they support people in developing action plans, etc.
Ki Performance Lifestyle Ltd.	Recommendations 8, 9 and 11	Pages 13-16	We agree with *Recommendation 8*; however we would include "objective" to the description of the "validated tool appropriate for the specific population or setting." Whilst we recognise that objective measures are not currently available in all areas covered by this guidance, accurate and objective measures of physical activity and sedentary behaviour in a free-living environment are available. These tools could be employed in both the assessment of physical activity and sedentary behaviour, as well as be integral to interventions aimed at changing these behaviours. We also strongly agree that an in-depth assessment should be carried out before starting any intervention. In addition to the recommended components, we believe the assessment should assess all elements of an individual's lifestyle and take place in a free-living environment; as such it could be defined as an audit. Without gaining a comprehensive view of the individual's lifestyle and behaviour, not only is it harder to select the correct intervention,	Thank you for your comments. Validation is an objective process, as such adding 'objective' should not be required. The latter issues you raise are covered in recommendation 8. However the PDG did not place restrictions on where an assessment takes place.

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			but any improvement cannot be accurately assessed.	
Ki Performance Lifestyle Ltd.			***Comment continued:*** Auditing and feedback are currently used to assess clinical performance; the same techniques can be applied to the patients themselves. The process of audit and feedback has been described as the measurement of an individual's professional practice and comparison of their performance against professional standards or targets with the aim of encouraging the individual to follow professional standards (Ivers *et al*., 2012). In the same way, an individual's health-related behaviours can be audited by measuring all aspects of their lifestyle and comparing the results to current guidelines. The results can then be fed back to the individual by a healthcare professional, who can then deliver a targeted intervention specific to the individual's strengths and weaknesses. Importantly, the intervention can be tailored to the individual's lifestyle, thus meeting *Recommendation 9*. Furthermore, as correctly noted in *Recommendation 11*, people who make the least change to everyday practices and routines are likely to be the most successful, specifically for long-term behaviour change. It is for this reason that auditing the individual's current lifestyle and identifying where small changes can be made that do not significantly disrupt their everyday practices and routines is of the upmost importance.	Thank you for your comments. Please see recommendations on behaviour change techniques which cover goals, planning, feedback and monitoring.
Ki Performance Lifestyle Ltd.			***Reference for Ki Performance Lifestyle Ltd. Comment:*** Ivers, N., Jamtvedt, G., Flottorp, S., Young, J.M., Odgaard-Jensen, J., French, S.D., O'Brien, M.A., Johansen, M., Grimshaw, J., and Oxman, A.D. (2012) Audit and feedback: effects on professional practice and patient outcomes. *Cochrane Database of Systematic Reviews*, Issue 6. Art. No.: CD000259. DOI: 10.1002/4651858.CD000259.pub3.	Thank you.
LighterLife	General		LighterLife expect behaviour change techniques and choice architecture interventions to feature prominently in the forthcoming NICE guidance *on*	Thank you for your comment. Please refer to

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			Managing overweight and obesity in adults - lifestyle weight management services, currently in development.	the Scope for Overweight and obese adults - lifestyle weight management guidance to see what it is aiming to cover: http://guidance.nice.org.uk/PHG/67/Scope/pdf/English
LighterLife	Recommendation 5	9	LighterLife welcome this recommendation and believe that local providers of weight management services could greatly contribute to the development of behaviour change interventions in the areas of life style change, diet and physical activity. For instance, LighterLife work through a network of local counsellors who are able to take into account the social and cultural context in which participants live, as people lose weight with people from their own community.	Thank you for your comment.
LighterLife	Recommendation 9	14	We strongly believe that tailoring interventions, to address both the cognitive and affective elements that support behavioural change is an absolutely crucial aspect of any programme. LighterLife provide weight management programmes within a small group setting, while being tailored to the needs of the individual participants. Our participants are supported by counsellors all the way through the programme in order to initiate life style changes aimed at supporting the maintenance of the weight loss they achieve.	Thank you for your comment.
LighterLife	Recommendation 10	15	LighterLife's programmes already apply a wide range of behaviour-change techniques with in the small group setting, informed by Cognitive Behavioural Therapy, Transactional Analysis, Solution Focussed approaches and attachment theories etc. by offering a structured, manualised, replicable	Thank you for your comment.

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			programme designed to increase self-efficacy, recognise and manage affect, to set clear goals, develop action and coping plans, and provide social and emotional support. Recognising, understanding and working with lapsing and relapsing, a common feature of traditional dieting, is an integral part of the LighterLife programme.	
LighterLife	Recommendation 11	16	As outlined above, LighterLife provide continued support to all participants through the work of individually assigned qualified counsellors who make sure that the person receives long-term monitoring, support and feedback.	Thank you for this information.
LighterLife	Section 2	23	We are concerned by the lack of practical advice on which techniques should be used to tackle specific behaviours and by the fact that 'relatively little is known about how behaviour change can be sustained'. LighterLife is keen to work with NICE to provide information and evidence about these issues.	Thank you for your comment.
LighterLife	3.5	25	We welcome the PDG's discussion of the role of commercial companies in contributing to behaviour change and the potential contribution they could make to behaviour-change programmes. LighterLife would be keen on exploring ways to collaborate in order to promote understanding about behaviours such as eating patterns.	Thank you for your comment.
LighterLife	3.18	28-29	As outlined previously, we would be keen to collaborate with NICE to ensure that behaviour-change services in the area of diet are of high quality and properly assessed. We believe that the data provided should be treated in a suitable way so as to ensure that commercially sensitive information is preserved.	Thank you for your comment.
LighterLife	3.42	33	LighterLife are disappointed by the decision not to make any recommendations on the use of choice architecture interventions. We believe that the evidence available around diet and weight reduction constitutes a	Thank you for your comment but the PDG do not agree that at this

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			suitable basis for developing specific recommendations in this area.	point any recommendations can be made on choice architecture interventions. The scoping review (details provided in expert testimony) did note that the majority of choice architecture studies are in the area of diet, but 'in the absence of a full systematic review, the PDG questioned whether such interventions did lead to a healthy diet." A further evidence synthesis on this approach is due to be published soon. The PDG advised that if this synthesis is published prior to the routine update of this guidance, the update should be bought forward.
LighterLife	4.1	34	Given the lack of specific recommendations outlined above, LighterLife believe that the research question should include a clear reference to choice architecture interventions relating to diet and weight loss. Given the extent of the obesity epidemic in the UK and the burden it creates on NHS resources,	Thank you for your comment – please see above – it is not clear yet whether further research

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			this should be a priority area for the development of evidence-based interventions.	is required in the area of diet/weight loss and a review of these interventions is being awaited
LighterLife	4.1	34	We welcome the recommendations for research made by the PDG, on the effectiveness of choice architecture interventions in commercial settings. As mentioned above, we look forward to further opportunities to provide evidence on the effectiveness of our interventions.	Thank you.
Living Streets	Rec 1	5	We would recommend that the final bullet in recommendation 1 calls on local authorities to identify both an elected and non elected member of cabinet and director of public health to ensure behaviour change strategies go beyond the four year political cycle.	Thank you for your comment. Please note that, although not part of the cabinet, the Director of Public Health is not an elected member.
Living Streets	Rec 3	7	When assessing the cost effectiveness of behaviour change interventions the guidance should highlight the importance of grey literature (non published project evaluations) to commissioners. This is particularly the case for new or emerging behaviour change techniques which have yet to be peer viewed by academic journals.	Thank you for your comment. We recommend that behaviour change interventions and programmes should be based on the best available evidence of effectiveness and we have not pointed in this guidance to sources of evidence. Commissioners can find further details in the

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				NICE behaviour change local government briefing.
Living Streets	3.4	25	We note that this guidance is aimed at people aged 16 and older. However, we are concerned that no further reference is made to the importance of behaviour change techniques for those under 16 and question where guidance for behaviour change interventions aimed at those under 16 sit within the NICE suite of guidance. Living Streets operates the national Walk to School programme which seeks to promote walking to school for both primary and secondary school children. Whilst the choice architecture intervention is focussed at parents of primary school children the choice architecture intervention at secondary school is very much based on the choices made by the children. Our Walk to School intervention began as a pilot project funded by the Department for Transport which saw us work in partnership with Hertfordshire County Council to work intensively with a cluster of schools. This work included using incentive schemes, promotional events, and working with parents and schools to identify and tackle local barriers to more walking. At the end of the project, walking to school had increased from 46% to 53%. Park and Stride (where parents drop off their children at a designated point within walking distance of the school) increased from 8% to 18%, and driving rates decreased from 36% to 19%**...Cont..**	Thank you for your comment. We aim to limit discussion of out of scope issues in guidance: in this case the scope was restricted to over-16's and NICE plans to produce guidance for other age groups in the future. The PDG agreed early in development that this guidance would not provide specific recommendations for a particular behaviour, but would focus instead on cross-cutting characteristics of effective individual level interventions. For topic specific information, please refer to other NICE public health guidance using this hyperlink.

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				Please also note that we are unable to accept or review additional evidence at this stage.
Living Streets			**Cont**…**This is one of the most effective interventions we have seen in terms of shifting the mode of travel to school - in the UK and internationally**. As a result of our focus on breaking down behavioural barriers with parents, we saw a 33% reduction in the number of children who perceived school being too far to walk and a 44% reduction in the number who perceived that it took too long to walk to school. In 2012, Living Streets - in partnership with Durham County Council - secured funding through the Government's Local Sustainable Transport Fund to roll out the outreach project in 11 local authority areas. In the first year alone we have launched Walk Once a Week (WoW) in 210 primary schools, reaching over 50,000 more children. We have also worked with 42 secondary schools and invested £70,000 in capital improvements to help remove environmental barriers to walking, which has leveraged in further match funding. By the end of the project in 2015 we will have collectively engaged over 1,000 schools (854 primary and 182 secondary). Early results replicate the success of the pilot project, with walking rates at participating primary schools increasing from 53% to 68%. **....Cont……** Cont…….	Please see response above. In addition, this seems to be a community level intervention, which would be outside the scope of this guidance.

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Living Streets			Our Walk once a Week (WoW) extension project for the Department of Health saw us working with 736 schools and over 118,000 children in order to increase walking levels in schools across England. 61,567 children and 6,515 parents took part in surveys which revealed a 25% increase in numbers of children walking to school (during the project lifetime) and a 35% decrease in car use. Before the WoW intervention, schools had a 43% walking proportion, and following the WoW interventions schools reached a peak of 59% walking in 2011, levelling at 54% in 2012 (the final year). Living Streets' Walk to School projects have had a clear positive impact on the number of children and young people walking to school over the last three years in the locations where it has been supported. The importance of school based interventions to increase walking levels was recognised by the National Institute of Health and Clinical Excellence (NICE) in its Walking and Cycling guidance in 2012. Therefore, there appears to be a contradiction in the use of school based behaviour change interventions in the walking and cycling guidance but guidance as to the use of choice architecture interventions such as Walk to School absent from the behaviour change guidance. Interventions at those under 16 can affect long term behaviour change later in life.	Please note that Walking and Cycling guidance and this guidance have different scopes (i.e. have different inclusion and exclusion criteria). As stated above, It is outside the scope of this guidance to discuss what should be delivered to under 16s - there is always a balancing act to be made when developing guidance to ensure that we can cover relevant evidence within the time and resources available for a piece of guidance.
Living Streets	Recommendation 3	7	We support the use of evidence based principles to ensure interventions are effective and cost effective. However, there are challenges when trying to assess the cost effectiveness for walking interventions for children because the standard HEAT (Health Economic Assessment Tool) cannot currently be used to assess reduced mortality of children.	Thank you for your comment. It is outside the scope of this guidance to discuss what should be delivered to children (under 16s).
Living Streets	Recommendatio	18	This section needs to make reference to the challenges of evaluating the	Thank you for your

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	n 17		effectiveness of behaviour change interventions for children. For example, there are challenges when trying to assess the cost effectiveness of walking interventions for children because the standard HEAT (Health Economic Assessment Tool) cannot currently be used to assess reduced mortality of children.	comment but this is out of scope.
Living Streets	General		The guidance should signpost back to other guidance throughout the recommendations to ensure clarity for the reader. Furthermore, it is important that the guidance frames the effectiveness of behaviour change interventions in a wider context beyond the scope of this guidance. For example, behaviour change interventions to increase levels of walking are predicated on the availability of clean, safe streets for walking. These wider determinants of health are refered to in the Walking and Cycling Guidance.	Thank you for your comment but this is out of scope (community and environment will be subject to separate guidance)
Living Streets	4.1	34	We wish to highlight two independently evaluated behaviour change interventions regarding walking to work and our Fitter for Walking programme. Details are below: A recent evaluation of Living Streets Fitter For Walking Project undertaken by Loughborough University provides UK based evidence regarding multi-component community-based interventions to promote walking. The project was independently evaluated in three ways: 1. Confidential interviews and focus groups with community members, local authorities and Living Streets staff; pedestrian counts; route user interviews and residents' surveys, by the British Heart Foundation National Centre for Physical Activity and Health (BHFNC) 2. Collection and monitoring of pledges from individuals, collected by Sustrans 3. An economic evaluation undertaken by the University of West of England. **Cont……**	We are unable to accept or review additional evidence at this stage.

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Living Streets			**Cont…..** Overall, the results showed: - 150 communities were helped in 12 Local Authority areas across 5 regions of the UK - Over £400,000 worth of streets improvements were made by Local Authorities - Over 10,000 people out walking in their neighbourhoods - 86% of the projects resulted in more pedestrians walking in the area	We are unable to accept or review additional evidence at this stage.

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			- 78% of individuals who signed up reported an increase in their day-to-day walking levels - 64% of these still reported an increase in walking six months later, showing long-term impact - Up to 46:1 benefit cost ratio for decreased mortality as a result of more people walking. For more details please see: http://www.livingstreets.org.uk/sites/default/files/content/library/Evaluations/FFW_Evaluation_Report_FINAL_31Jan2012.pdf **Cont……**	
Living Streets			**Cont…..** Living Streets Walking Works – Pledges - Follow up survey results - Sustrans (2012) Living Streets Walking Works – Pledges - Follow up survey results**)** Walking Works is a Living Streets project, funded by the Big Lottery Fund as part of the Travel Actively portfolio. In total 33,657 individuals completed Walking Works pledges between 2009 and 2011, 457 of these completed the follow up survey. This report presents direct comparisons of responses on walking levels and physical activity. Before the project 35% of respondents who made a pledge at registration were achieving the recommended levels of 30 minutes of physical activity on	We are unable to accept or review additional evidence at this stage.

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			five or more days per week. After the project this increased to 49% of pledge respondents. The proportion of respondents walking for some or all of their journey to work on five or more days per week increased from 38% to 44% and from work increased from 35% to 44% as a result of the programme. The proportion of respondents who walked at lunch time on five or more days a week increased from 21% to 26% as a result of the project. The proportion of respondents who did not walk at lunch on any days of the week decreased from 26 % to 22%...**...Cont……**	
Living Streets			**Cont…**The number of respondents who walked for other journeys during the working day on five days a week increased from 26% to 34%. **Change in levels of walking for different purposes** • 32% of 423 respondents said the amount of walking they do for journeys to work had increased • 33% of 424 respondents said that walking from work had increased • 43% of 427 respondents said lunchtime walking increased • 59% of 444 respondents said that the amount they walk for leisure had	We are unable to accept or review additional evidence at this stage.

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			increased. Following the redesign of the Living Streets website in 2011 a question was introduced about overall walking, 94% of 31 respondents felt that their overall level of walking had increased since making their Walking Works Pledge. **After participation** Respondents were asked which statements applied to them after taking part in the project. The most common responses were "I feel fitter" (54%), "I feel more healthy" (50%), "I am more active" (44%) and "I feel less stressed" (44%).…Cont…..	
Living Streets			**Cont…… Value of health benefits** Health benefits from increased walking levels can be assessed through the World Health Organisation (WHO) Health Economic Assessment Tool (HEAT) which puts an economic value on reduced mortality. The number of beneficiaries was calculated based on the proportion of survey respondents that were walking to and from work on three or more days per week following participation, having not reported this at registration. The calculated number of beneficiaries was 2,798 assuming that survey respondents were representative of all participants. The mean average time reported walking to or from work was 15 minutes. Based on this, a journey time of 30 minutes per working day was applied. This increase in mileage was inputted into the WHO HEAT tool, and the current value of reduced risk of mortality resulting from the new walking trips, when accumulated over 10 years, was estimated by HEAT to be £3,881,000 in total. The economic benefit of this through reduced number of sick days is estimated to be worth £ 1,117,000 accumulated over 10 years.	We are unable to accept or review additional evidence at this stage.

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BHF National Centre for Physical Activity and health, Loughborough University	General		The role of the BHF National Centre for Physical Activity and Health at Loughborough University (BHFNC) is to provide leadership and advocacy to raise the profile of physical activity, call for greater investment in health promotion and physical activity and improve the infrastructure and services provided to support more active lifestyles. We are committed to developing and promoting resources, training, information and guidance that will help professionals encourage people to be more physically active. Our primary aim is to develop, translate and disseminate research and practice-based evidence to expand and improve effective practice of physical activity promotion in the UK. The BHFNC is pleased to respond to this guidance. Behaviour change is an important component of physical activity programmes that help people to make a number of lifestyle changes to improve their health and wellbeing. The BHFNC supports this guidance that provides greater clarity then previously available on the evidence relating to what behaviour change techniques should be used, when and by whom. If you have any queries about this contribution or require any further information please contact Bob Laventure (Acting Director) B.M.E.Laventure@lboro.ac.uk	Thank you.
BHF National Centre for Physical Activity and health, Loughborough University	General		This draft guidance, when compared with the previous NICE Public Health Guidance 6 on behaviour change, does move the quality and quantity of advice forward and offers a considerable amount of guidance in the 18 recommendations. As a result the guidance is content-heavy and the necessary cross-referencing is confusing. In particular the Programme Development Group might reconsider the extent to which the guidance could be condensed or the ordering of the recommendations particularly relating to the transitions from Commissioning principles (Recommendation 2) and the sequence of planning (5) design (6)	Thank you for your comment. It is a balancing act how much cross-referencing to other recommendations is made; and some stakeholders have requested more cross-referencing. In relation to ordering of

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			Delivery (7), training (12) and evaluation (3 and 17). The current sequencing does not seem to offer a smooth flow or continuity and changes from broad principles to detail and back again.	the recommendations, these have been reordered. Please note that recommendations will also be available within NICE pathways, in which all recommendations can be seen together under sub-headings. In relation to evidence, all supporting documents – reviews and expert testimony are available via the web page for this guidance.Links to evidence are made explicit for each recommendation in a separate document supporting the guidance. Recommendations themselves are not written referencing every piece of evidence.
BHF National Centre for Physical Activity and health, Loughborough University	General		The BHFNC is pleased that the guidance is supported by good evidence to support physical activity interventions but is rather equivocal about broader interventions where physical activity is considered alongside or together with other behavioural interventions, such as diet or smoking. Given the current	Thank you for your comment. The PDG decided early in development that this guidance

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			policy focus on interventions to promote whole health and wellbeing, some additional clarity would be welcome.	would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE public health guidance which is able to cover evidence on interventions for a particular behaviour in more detail.
BHF National Centre for Physical Activity and health, Loughborough University	General		Although clarified in the Guidance Glossary, the references to time related interventions (very brief, brief, extended brief (and intensive interventions) whilst made applicable to different opportunities for intervention, do not appear to be supported by sufficient evidence on efficacy. The PDG might wish to look at providing more evidence to support these different interventions.	Thank you for your comment. The PDG do not look at additional evidence at this stage.
BHF National Centre for Physical Activity and health, Loughborough University	General		Compared with the previous NICE Public Health Guidance 6 on behaviour change, this Draft Guidance does provide evidence of a greater quantity and quality, a considerable increase and improvement. As a result the guidance is content-heavy and at times, the need for cross referencing is copious. The PDG might wish to consider the amount of content or the number of recommendations. PDG might also consider the ordering of the recommendations particularly relating to the transitions from Commissioning principles (Recommendation 2) and the sequence of planning (5) design (6) Delivery (7), training (12) and evaluation (3 and 17). The current sequencing does not seem to offer a smooth flow or continuity and changes from broad principles to detail.	Please see response above about ordering of recommendations.

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BHF National Centre for Physical Activity and health, Loughborough University	Introduction		The BHFNC welcomes the reference to further/work research into Choice Architecture as it is of increasing interest to the promotion of physical activity. However, reference to work that is unsupported by evidence can often lead to a delay in decision making by commissioners. BHFNC would see the development of this evidence as a priority area.	Thank you for your comment. This is highlighted in the research recommendations and considerations.
BHF National Centre for Physical Activity and health, Loughborough University	Introduction		The guidance recognises the issue of age limits for guidance on certain behaviours and that this guidance is for people aged 16 or over. However, given the significant amount of work that is undertaken across health, local government and the independent sector to promote physical activity with young people of school age, it is important that such work is underpinned by sound evidence (where it exists) relating to behaviour change. There is no cross referencing to other NICE guidance on physical activity and young people. Diet and physical activity intervention should not have an age limit imposed. Intervention should be based on individual need and not on lower age limits. The PDG should consider signposting what evidence does exist to support physical activity and diet with young people under 16	Thank you. We do not reference NICE guidance for under 16s as this is not covered by this guidance.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 1	5	The BHFNC is supportive of the recommendation to identify a named strategic local authority lead for specific behaviours (e.g. physical activity) which may provide a consistent and clear approach to strategic development and partnerships.	Thank you for your comment.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 2	6	The BHFNC welcomes this recommendation and its commitment to ensure that health inequalities will not increase and where possible be reduced.	Thank you for your comment.
BHF National Centre for Physical Activity and health,	Recommendation 3	7	The BHFNC welcomes the recommendation to commission interventions that are proven to be effective over the long term. This may require substantial	Thank you for your comment.

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Loughborough University			changes to ensure that commissioning moves away from short term "quick hits" towards a great emphasis on sustained interventions to ensure long term lifestyle change. The BHFNC is concerned that the evidence that supports brief interventions will appear to be more attractive as it is seen to be a cheaper option to commissioners.	
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 3	8	The BHFNC is in agreement that interventions for which there is no evidence should be adequately powered and evaluated. Further guidance on evaluation is included in recommendation 17, it seems that evaluation and research are being used interchangeably. Should interventions for which there is no evidence be evaluated or researched?	Thank you for your comment. The term 'research' has not been used in either of these recommendations, both discuss evaluation. Reference to researchers and funders of research has been given.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 5	10	The BHF supports this and subsequent recommendations relating to intervention fidelity. We believe this will add to the effectiveness of interventions as experience suggests this is not currently part of programme planning, monitoring or evaluation.	Thank you.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 6	10	The BHFNC believes that the recommendation on documentation/manuals/protocols and intervention design will be very valuable. There is a lack of good quality guidance in the professional domain, partly as a result of researchers not communicating findings on evidence-based practical guidance on intervention design or professionals evidencing their own work.. Professional support is a key component of the BHFNC work to promote physical activity and this recommendation could be instrumental in improving the quality of practice and interventions.	Thank you.
BHF National Centre for Physical	Recommendatio	13-14	This recommendation suggests that intervention is at an individual level. Some	Thank you for your

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Activity and health, Loughborough University	n 8		interventions (e.g. work place interventions, peer-led intervention involve groups. Would these not be included as the overall guidance is about individual interventions?. Participant assessment is not always possible in these situations.	comment. This guidance is for individual level interventions; while an individual-level intervention can be delivered to groups, we would expect the assessment of a person's behaviour and needs to be completed by an individual on their own and for this information to be available when delivering an intervention. Where interventions involve assessment then we would expect this detail to be provided in manuals, etc as detailed in previous recommendations. This recommendation is about the delivery of assessment of a person's behaviour and requirements for an intervention.
BHF National Centre for Physical	Recommendatio	13 -14	Would this recommendation may be better described as 'design' rather than	Thank you for your

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Activity and health, Loughborough University	n 9		'delivery'. This would firmly root the individual needs as the starting point of an intervention. The guidance needs to recognise that there may be a disparity between professional and public preferred outcomes. For example, participants may seek alternative outcomes after intervention, such as wellbeing, whereas the professional outcome would focus on improved health.	comment. All recommendations on delivery should be reflected in the design process as they constitute what makes up the intervention. The guidance recommends that a person centred approach is taken which would help to ensure that an intervention reflects an individual's preferences.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 10	15	The BHFNC would like more evidence for the inclusion of some behaviour change techniques but not others. The guidance would therefore benefit from further detail on the criteria used to determine which behavioural change techniques are appropriate. The BHFNC recognises that motivation is a key additional factor in supporting or impeding behaviour change interventions. This should be mirrored throughout the techniques employed and needs greater recognition..	Thank you for your comment. The evidence base for these specific techniques is highlighted in a supporting document for this guidance (previously in section 9 of the draft guidance) which links recommendations to the evidence and is discussed in the considerations. Motivation has been highlighted in other

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				recommendations on delivery.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 11	16	The longer term maintenance of behaviour change is dependent upon motivation felt by the participant (which may fluctuate over a period of time as referenced to the need to anticipate lapse and relapse behaviour. This should also be reflected in the on-going monitoring and feedback offered to participants. To ensure on-going support for past participants this recommendation needs to relate more closely with Recommendation 2 as the support needed to ensure maintenance needs to be considered in the commissioning process.	Please see the response above.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 12	16	As an organisation that provides training to a range of health and other professionals, the BHFNC welcomes and supports this recommendation and would welcome greater clarity on funding that might be secured to ensure appropriate training and access to all potential trainers for those offering interventions. The current financial climate in both health and other services would indicate that this recommendation, no matter how important, might serve as a hostage to fortune.	Thank you for your comment. Funding and staff management are beyond the scope of this particular guidance: In this instance we envisage these decisions will be made locally, and with reference to local needs and structures.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 14	18	Given the wide range of professionals that are in a position to deliver different forms of behaviour change interventions, The BHFNC recommends that a definition of 'behaviour change practitioner' is added to the glossary.	Thank you for your suggestion, a glossary term has been provided.
BHF National Centre for Physical Activity and health, Loughborough University	Recommendation 17	21	Whilst the BHF supports the framework for evaluation proposed within the guidance, there appears to be a disparity between this recommendation and recommendation 3 where it seems that evaluation and research are being used interchangeably. Greater clarity would be appreciated on whether	Thank you for your comment. Evaluation is a form of research, however the term

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			interventions for which there is no evidence be evaluated or researched.	'research' has not been used in the recommendations so we are not sure where the confusion is arising from.
Lundbeck Ltd	General		Lundbeck is an ethical research-based pharmaceutical company specialising in central nervous system (CNS) disorders, such as **depression and anxiety, bipolar disorder, schizophrenia, Alzheimer's, Parkinson's disease, with an active interest in alcohol policy.**	Thank you for this background information on your organisation.
Lundbeck Ltd	General		Lundbeck welcomes and supports the updated public health draft guidance on 'Behaviour change' and the inclusion of alcohol as a key area within this. As is outlined in NICE's Public Health Guidance on Alcohol use disorders, alcohol-related harm presents a major public health challenge.[1] Therefore there is a clear and well-evidence need for both population-level interventions, and interventions aimed at individuals, the latter of which is the subject of this current review. The development of individual-level approaches on alcohol should be seen as an integral part of the commissioning strategy at a local basis. Such interventions can help to make people aware of the dangers of unsafe alcohol consumption, and can flag up potential problems to healthcare professionals at an earlier stage than compared to a patient being admitted with liver disease for instance. There is also strong evidence which suggests that early interventions are effective at changing behaviour and producing long-term savings.[2]	Thank you for your comment.
Lundbeck Ltd	Recommendation 1	5	It is important that the commissioning of all individual-based interventions, including those targeted at addressing alcohol misuse, are based on sound and well-evidenced assessments of need at a local level. Joint Strategic Needs Assessments (JSNAs), which are referenced in this draft guidance as a	Thank you for your comment. We are not able to include reference to materials not

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			means of identifying local needs, are therefore to be considered an integral part of this process. A key function of the JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities, and they are also expected to underpin local authorities' respective health and well-being strategies. However, evidence submitted to the Communities and Local Government Committee (CLGC) consultation on the role of local authorities in public health suggested that JSNA development in the build-up to the transition of public health commissioning responsibility was "patchy and variable", while the development of Joint Health and Wellbeing Strategies was meanwhile described as "very mixed across the country".[3] It is therefore essential that there is clear guidance on the availability of appropriate data sources for commissioners to utilise when developing policy and strategy around individual-level interventions for alcohol misuse. One such useful source of data is Alcohol Concern's 'Alcohol Harm Map' (produced with support by Lundbeck), which was released in October 2012 and contains information on the level of alcohol-related harms and its associated costs at a local authority level.[4]	examined by the PDG. The behaviour change local government briefing provide details on data sources, and recommendation 17 highlights the role of national organisations to provide support on this,
Lundbeck Ltd	Recommendation 5	9	It is important to ensure that any individual-based interventions targeted at addressing alcohol misuse take into account the best means of reaching those at whom the intervention is targeted at. Commissioners of brief intervention and advice services for instance, which are shown to be effective when there is limited contact time available, should take into account widening the scope of delivery, from simply traditional healthcare-settings.	Thank you for your comment. The recommendation concerns the broad principles of what to do in the planning stage.

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			While people who may be drinking at unsafe levels will not necessarily come from one distinct social grouping, with evidence suggesting that alcohol dependence impacts upon a broad range of socioeconomic groups[1], there are a significant proportion of people at risk of health inequalities that would benefit from independent brief interventions but may not come into contact with health professionals through more common routes, such as GP services and hospital-settings. Therefore, in respect of ensuring equitable access for those that would benefit from help, alternative venues should be considered for the delivery of brief interventions, including the pharmacy setting or community centres. The Healthy Living Pharmacy Service in Portsmouth is one such example of this, which saw NHS Portsmouth's Alcohol Intervention Team (AIT) devise an alcohol-specific training scheme for all pharmacy staff members in 2010 - from counter-staff to technicians - enabling them to deliver structured brief interventions. In total, 37 local pharmacies were involved in the project, and during the course of one month, pharmacies in Portsmouth made over 3,600 alcohol interventions and referred 29 individuals to a specialist alcohol service. Successful interventions did not just entail referral to a specialist alcohol treatment service, but also included encouraging a client to set a goal related to their alcohol consumption, for instance two drink-free evenings a week. Widening the scope of individual-level interventions also supports point 3.27 (p30) of this draft guidance, in which the PDG recommended that interventions should not focus solely on those carried out by GPs and other medical staff. In encouraging the uptake of screening and referral-based interventions in other	This recommendation includes providers of behaviour-change programmes, which would include a wide range of settings including pharmacies.

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			settings, such as pharmacies, this would provide an effective means of reaching 'vulnerable groups' as recommended, as these groups may be less likely to access traditional health pathways.	
Lundbeck Ltd	Recommendation 7	12	Lundbeck welcomes the recommendation that 'all staff in contact with the general public should, if they wish, be trained to deliver a very brief intervention'. As referenced above, there are previous examples where the delivery of alcohol-based brief interventions by a broad spectrum of staff in contact with the general public - not necessarily those limited to those in traditional healthcare settings - has been shown to be effective in respect of delivering effective individual-based interventions, especially to traditionally 'hard to reach' groups. However, it is important that there is comprehensive guidance available to commissioners in terms of training staff effectively, which includes references to best practice case-studies (such as NHS Portsmouth's Alcohol Intervention Team's alcohol-specific training scheme). This will ensure that interventions carried out by non-specialist staff are done so effectively and with the outcome of changing behaviours that may be damaging to health, such as reducing alcohol consumption over a sustained period of time. Lundbeck also welcomes the recommendation that 'all staff dealing with the general public and behaviour-change service providers have the potential to provide medium-intensity interventions (extended brief interventions) for people they regularly see', for instance those that are involved in risky behaviour such as higher risk drinkers. As evidenced in previous NICE guidance[1], extended brief interventions have been demonstrated to be effective in the reduction of alcohol consumption. Ensuring that all staff who deal with the general public and behaviour-change service providers are equipped to carry out such interventions will therefore	Thank you for your comments. Recommendation 11 covers commissioning for training.

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			better enable people to effectively manage and reduce their involvement in risky behaviour, such as higher risk drinking.	
Lundbeck Ltd	Recommendation 12	16	Lundbeck welcomes the recommendation that those who commission staff training should incorporate brief interventions, including extended brief interventions, into a competencies framework for training staff. As previously mentioned, extended brief interventions provide an effective and well-evidenced means of managing a person's risky behaviour, such as reducing the consumption of alcohol. Ensuring that this is included as a training competency will help embed this type of intervention into the working knowledge of training staff, and regular refresher training will ensure that the quality of delivery is well maintained.	Thank you for your comment.
Lundbeck Ltd	Recommendation 18	22	Lundbeck recognises and welcomes the need for national organsations to provide support for behaviour-change interventions and programmes, and are encouraged that Public Health England recently issued a call to action to increase the uptake of the NHS Health Check.[6] The NHS Health Check includes an alcohol risk assessment, on the basis that alcohol consumption is within the top seven causes of preventable mortality in England. This provides a valuable central steer therefore for the provision of well-evidenced individual-level alcohol interventions for local health professionals and behavioural change commissioners. However, it is also important that Public Health England provides clear guidance on the best means to enact such behaviour-change interventions if it is to 'empower public health leaders locally with the evidence and rationale for the programme'.[6] Previous best practice guidance on the NHS Health Check (before its most recent iteration) made it clear that commissioners should 'adopt local models of delivery' that 'suit the needs of their often diverse local	Thank you for your comment. Please see revised recommendation on national support (now recommendation 17).

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			population'.[7] This tied closely with concerns that interventions based solely in General Practice could potentially widen health inequalities, as many groups most at risk from the relevant assessment areas may not choose to access the programme in the General Practice setting. In March 2013 a guidance note from PHE and DH was shared with local authorities and other key partners setting out a number of general delivery approaches that local commissioners could consider when commissioning individual-based interventions, including offering 'opportunistic elements' of a programme', in conjunction with GP delivery. However, it is important that there is clear guidance provided on the types of setting that these interventions could be delivered from, and that there is available evidence to support this.	
Lundbeck Ltd	Glossary	36	Lundbeck would suggest that the glossary entry 'Extended brief intervention' is expanded to incorporate the contents of recommendation 11 within Public Health guidance 24; 'Alcohol-use disorders: preventing harmful drinking'.[1] The recommendation, which is supported by evidence statement 6.11, includes information on who should take action, as well as further guidance on what action they should take, such as providing motivational interviewing or motivational-enhancement therapy, follow-up assessments, and where necessary, referral to a specialist alcohol treatment service. A key aim of extended brief interventions is to encourage people to reduce the amount they drink to low risk levels, and it would be a useful addition if the glossary entry made reference to this.	Thank you for your comment. Glossary items are kept as succinct as possible. Please note that the PDG made a decision early in development that this guidance would not provide specific recommendations for a particular behaviour but would instead focus on cross-cutting aspects of effective interventions. . Please see other

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				NICE public health guidance which is able to cover evidence on interventions for a particular behaviour in more detail.
Macmillan Cancer Support	Rec 1	P5	Recommend that there is need to ensure that there is an appropriate evaluation mechanism to determine that success of the strategy/policy	Thank you for your comment. Evaluation recommendations are provided later on.
Macmillan Cancer Support	General		One of the key barriers for professional delivering behaviour change interventions quoted it time. It not only needs to be wrtten into job descriptions but time is made. This may include changing current appoint ment systems. For example GP's only get 10 minutes to diagnose and treat – no time for anything else	Thank you for your comment.
Macmillan Cancer Support	Rec 6	P11	The manual should make clear the range of interventiosn that can be delivered depening on time eg. Breif intervention to more indepth.	Thank you for your comment. We feel the details included in the recommendation would cover these issues.
Macmillan Cancer Support	Rec7	P12	It is not clear if community staff include local government staff. May fitenss professionals are ideally placed and have the training to deliver behaviuor change interventionsin relation to physical activity.	Thank you for your comment. Community staff are no longer referred to. The recommendation covers 'staff working in health, wellbeing and social care services who have contact with the

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				general public.' This would include fitness professionals.
Macmillan Cancer Support	Rec 15 ``	P 19	There is an issue about how health information in provided the key is good communication skills and using a patient centred approach and using a guiding as opposed to telling approach – I appeciate this fits with the ethos of the guidance but think it needs spelt out in more detail	Thank you for your comments. Many of the highlighted skills are about being patient-centred; for example, rapport and relationship-building, developing motivation through reflective listening and empathy. The introduction to this guidance now states that 'The recommendations should be implemented together, using a person-centred approach'
Motivational Interviewing Network of Trainers	3	7	We are supportive of the necessity for quality assurance and fidelity checks. There are well developed and validated technologies for QA and fidelity in Motivational Interviewing including the Motivational Interviewing Treatment Integrity (MITI) scale and the Behaviour Change Counselling Index (BECCI).	Thank you for your comment. We are not able to include reference to materials not examined by the PDG and that have not been subject to a review process.
Motivational Interviewing Network of Trainers	4	8	We agree that the importance of practitioners being supportive, motivating and empathetic should be an important aspect of training. The relational aspect of working with patients to promote behaviour change is in our view under-	Thank you for your comment.

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			emphasised in PH6 at the expense of technical/behavioural interventions and we feel that this point could be helpfully brought more to the foreground. We note that the evidence review for PH6 supports this recommendation.	
Motivational Interviewing Network of Trainers		9	We are supportive of the point that staff should be supported in delivering behaviour change interventions, including feedback on practice. This point could be strengthened to promote feedback using validated coding instruments such as the MITI and on-going supervision from trained trainers/supervisors.	Thank you for your comment. Please note that feedback on practice is covered in recommendation 14. Specific tools are not recommended that have not been part of our review process.
Motivational Interviewing Network of Trainers	6	11	We welcome the move to manualise intervention techniques, though note that in some MI studies manualisation is associated with lower efficacy, possibly corresponding to a constraint of experienced practitioners (Miller and Rose 2009). We do not believe that evidence supports the necessity for constraining a manual to a taxonomy at this point: see notes to section 3.34 below.	Thank you for your comment. The recommendation has been re-worded. It states that there should be 'a clear definition of the behaviour change techniques used so that each component can be replicated (for example, by using a taxonomy)'.
Motivational Interviewing Network of Trainers	7	12	We welcome the recommendation that all NHS staff should be trained to deliver brief interventions. We would also welcome a statement that such interventions should be client/patient centred in spirit.	Thank you for your comment. The introduction to this guidance now states that 'The recommendations should be implemented together, using a person-

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				centred approach'
Motivational Interviewing Network of Trainers	8	13	We welcome the statement on the importance of client assessment. This could be usefully expanded to include a statement on the importance of client/patient strengths e.g. 'the personal and social resources they possess that can be recruited/employed to support any change' The substance use field is into 'recovery capital' and it might be appropriate here.	Thank you for your comment. This is encapsulated in the glossary definition for capability, opportunities, and motivation.
Motivational Interviewing Network of Trainers	9	14	We welcome the statement that it is important to recognise that there are times when people are more open to change, however it is also important to recognise that there are times when people are not ready or ambivalent. We believe that the stress on action planning and goal setting this document is not always appropriate and can be counter-productive at the wrong time or in the wrong situation. Clearer guidance should be given for clients/patients who are less ready to change as effective approaches do exist for this group.	Thank you. We have added 'Also recognise when offering a behaviour change intervention may not be appropriate due to personal circumstances.' The recommendation on assessing need should ensure that an intervention is appropriate to the needs of the client. Recommendation 10 on techniques highlights the techniques for which there is evidence of effectiveness in behaviour change.
Motivational Interviewing Network of Trainers	10	15	See previous note. We believe there is an over-emphasis on technical/behavioural approaches in this document. There are times when patients will not be ready for these techniques and where they can be counter-productive. Barriers to change in healthcare settings are often	Thank you for your comments. These techniques are highlighted as these are the ones for which there is good

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			relational/interpersonal and an over-emphasis on technical/behavioural approaches will not address this issue.	evidence of effectiveness. The evidence base for these specific techniques is highlighted in a document which links recommendations to the evidence and is discussed in the considerations. It is also recommended '• Consider using other evidence-based behaviour change techniques that may also be effective. See NICE guidance on alcohol, diet, physical activity, sexual behaviour and smoking for details of specific techniques.'
Motivational Interviewing Network of Trainers	12	16, 17	We welcome the recommendation for the use of trainers with proven skills and knowledge and that training is monitored, and for the necessity of refresher training. We welcome the recommendation for evaluation of training. However we note that the evidence base for what works in training is limited (e.g. Madison, Loignon and Lane 2009).	Thank you for your comment. Please see linked document (previously section 9 of the draft guidance) for the evidence base associated with the training recommendations.
Motivational Interviewing Network of Trainers	13	17	We welcome the recommendation for wide adoption of behaviour change knowledge and skills. We believe that the ask-advise-assist model is an expert led, non-patient centred approach which is at odds with other current UK policy guidance recommending more patient centred approaches e.g. the DH (2013) *Helping people make informed choices about health and social care* or	Thank you for your comment. The PDG developed this recommendation in the context of a person-

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			DH (2010) *Equity and Excellence: Liberating the NHS*, both of which promote shared decision making and patient centred practice.	centred approached, and we do not agree that it is at odds with a patient-centred approach.
Motivational Interviewing Network of Trainers	14	18,19	We welcome the general principles for training, particularly the recognition of the need for time and resources. The evidence from studies in the motivational interviewing field (e.g. Miller 2004 and beyond (e.g. Heaven *et al* 2006) suggest that there is very little skill retention from one off training events and that on-going supervision, monitoring and education is an essential part of producing change in most practitioners.	Thank you for your comment.
Motivational Interviewing Network of Trainers	15	19	We welcome the comments in this section around developing motivation through reflective listening and empathy. We agree that it is important to ensure practitioners develop skills in encouraging and enabling people to change and to manage their own behaviour, though would say that it is also important (in the service of empathy and client/patient centeredness) to know when and how to hold back on these skills.	Thank you for your comment.
Motivational Interviewing Network of Trainers	16	20	We welcome the recommendation for recording of sessions and using reliable observation tools with recordings or transcripts. This may not be feasible or appropriate for very brief interventions. We largely welcome the recommendations around feedback. Good practice in adult learning suggests that rather than give the learner clear targets, that targets should be negotiated and co-produced between trainer and learner as adult learning self efficacy is correlated with performance (e.g. Phillips and Gully 1997).	Thank you for your comments. The recommendation states that this is the 'ideal' way to undertake an evaluation, so other ways of assessment are possible. The recommendation has been amended to 'negotiate and set jointly agreed goals and an action plan'.
Motivational Interviewing	3.34	24	We have some concerns regarding the relative weight placed upon the	Thank you for your

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Network of Trainers			taxonomy of Abraham and Michie. We applaud the fact that behavioural scientists are trying to establish which components of behaviour change interventions might be helpful to patients, and appreciate the efforts that have been made to that end. However, we need to be cautious about placing too much emphasis upon a taxonomy, which is clearly still evolving, at the present time. No evidence is presented within the draft guidelines this is a valid and reliable way of categorising interventions as they currently stand. We are particularly concerned that the taxonomy does not seem to be a good match for some of the theoretical basis of motivational interviewing (Miller and Rose 2009) or for some of the interventions of motivational interviewing (especially those centred on relationship building as a core component of the intervention), particularly as the evidence base for motivational interviewing is growing. We believe that, at the current state of play in behaviour change research, where effect sizes are generally small whatever the theoretical school of the practitioner, it is premature to attempt to categorise effective interventions in anything but a tentative and provisional way.	comments. The taxonomy was used by the review teams as the most up-to-date taxonomy of behaviour change techniques used across behaviours. Work has shown it is a reliable taxonomy (please see context section of the guidance) and work is on-going to establish validity. The PDG also considered evidence from a range of other sources, including expert testimony drawn from a wide range of professionals which can be accessed via the web page for this guidance. The PDG recognised both the advantages and the limitations of a taxonomic approach, and were cautious when making decisions about which techniques to recommend. All

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				techniques that have been recommended are clearly described. Neither our evidence reviews nor our expert witnesses identified research suggesting that the taxonomy could not be applied to motivational interviewing interventions, furthermore no evidence to that effect was submitted when we held a stakeholder call for evidence. We will be reviewing the guidance for update at 3 years post publication and if new evidence comes to light to support the points you raise it will be considered during the update review process.
Motivational Interviewing Network of Trainers			Any categorisation or taxonomy should be strictly informed by the evidence and should not be used as a set of criteria for accepting or rejecting evidence that is difficult to fit to the model. The document cites the MRC complex intervention guidelines (2008) which state that 'A good theoretical understanding is needed of how the intervention causes change, so that weak links in the causal chain can be identified and strengthened'. The Abraham	The taxonomy was not used to accept or reject evidence, it was used to categorise the techniques used within interventions. You can read

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			and Michie taxonomy does not seem to fit this description as it seems to preclude elements of MI (particularly those that relate to relational process) regarded as essential by its proponents. In this respect, we question whether the reviewers may have inadvertently followed the path described by one of the contributors to the expert review, Ray Pawson, who notes that 'many crucial elements of behavioural change are overlooked because of the way programme evaluation is pursued'.	more detailed explanations of the how evidence was identified, synthesised and used in the evidence reviews that are currently available on the NICE website and which will remain available once the guidance is published via the web page for this guidance. We would encourage you to look at these, as they address the majority of issues and concerns that you raise.
Motivational Interviewing Network of Trainers	3.34	32	See previous note.	Please see responses above.
Motivational Interviewing Network of Trainers	3.37	32	The statement on initiation of a conversation and rapport building is weak, possibly reflecting the theoretical bias previously identified. We suggest that this section be strengthened with attention paid to the detail of how rapport is built through thoughtful and constructive conversations with a similar level of attention to that which is given in the document to specific behavioural interventions. We note that one of the experts in the review, Colin Greaves, identified this as 'a critical skill set' before listing 'using a guiding style; open ended questions; affirmation; reflective listening; rolling with resistance' – key components of Motivational Interviewing. This would be consistent with the findings in evidence review 3 (see below).	Thank you for your comment. Please note that this guidance is not intended to be a training manual. The recommendation is based on expert testimony and review 3 evidence. The consideration has had some amendments. All NICE guidance goes through an editing process to ensure

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				guidance is written in as plain English as possible to ensure it is clear to a wide audience.
Motivational Interviewing Network of Trainers	1.2	50	The literature review for Motivational Interviewing is dated, possibly reflecting the theoretical bias already identified. There have been many individual studies and several good meta-analyses since Dunn 2001. We suggest a further review of the motivational interviewing literature, perhaps using the bibliography at http://www.motivationalinterviewing.org/bibliography as a starting point. A more recent review which may be more helpful and includes a meta analysis of the available data (Lai, Cahill, Qin & Tang, 2010), from the Cochrane Database of Systematic reviews. Although they still note caution in interpretation due to variability in interventions and fidelity, and the possibility of publication bias, they concluded that MI yielded a *modest but significant increase in quit rates in comparison to brief advice or treatment as usual* – a different conclusion to the Dunn review cited.	Thank you for your comment. Please note that Evidence statement 1.2 comes from review 1, which was a review of existing NICE public health guidance, hence only evidence included in these pieces of guidance was assessed. We are unable to accept or review additional evidence at this stage.
Motivational Interviewing Network of Trainers	1.7	52	We have serious concerns that Motivational Interviewing is characterised as a 'poorly defined term' and would refer the authors to Miller and Rollnick (2013) for a clear definition. We have serious concerns that Motivational Interviewing is described as 'intervention function: Persuasion'. This is a major misrepresentation of Motivational Interviewing which is often contrasted with persuasion. We are particularly concerned that this is not an innocent error but is again a product of an attempt to prematurely fit interventions into a scheme that is not yet sufficiently well developed to describe all effective interventions for behaviour change. Although we are concerned at a conceptual level about the taxonomy and 'behaviour change wheel', if it is thought necessary to incorporate motivational interviewing into such scheme, a better fit may be IF9 enablement rather than IF2 persuasion.	Thank you for your comment. Motivational interviewing is not viewed as a poorly defined term, the issue is that it is poorly defined by authors of papers that say they use the technique. This is one of the main difficulties with identifying techniques, hence the recommendation that intervention details are

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				provided in publicly accessible manuals. Intervention function 9 "Enablement" was considered by the review team to not be a good match for the descriptions of MI provided in the guidance and evidence tables. IF 9 (enablement) is defined as "Increasing means/reducing barriers to increase capability (beyond education and/or training) or opportunity (beyond environmental restructuring)", with the examples of this being: "Behavioural support for smoking cessation, medication for cognitive deficits, surgery to reduce obesity, prostheses to promote physical activity".
Motivational Interviewing Network of Trainers	General (external	65	We note that the authors did not have time to contact study authors for more information about their interventions. This is less than ideal practice in	Inability to contact study authors for further details

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	evidence review 2)		conducting systematic reviews of complex interventions. We are concerned that this may have contributed to the poor understanding of Motivational Interviewing previously identified (note 1.7 p52), and therefore potentially other behaviour change interventions too. Additionally, by only applying taxonomy labels to the interventions as labelled within the articles (which are likely to have been restricted by word and space limits by the publisher) the authors are likely to have failed to identify codable, fundamental components of behaviour change interventions that actually took place. It seems they may also have taken the risk of assuming components that did not occur within those interventions were present, by using their judgement from information they have read elsewhere about those interventions. There is also a high probability that intervention components and functions falling outside the taxonomy and behaviour change wheel have gone unrecognised, and opportunities may have been missed to further inform these models. Within MI for example, some of the intervention components that appear to have been missed would include affirmations and reflective listening. This perhaps reflects a poor understanding of the intent of the taxonomy by the company performing the review, rather than an intrinsic problem with the taxonomy itself (taxonomies are constantly evolving frameworks, rather than rigid structures 'set in stone').	of interventions is acknowledged as a limitation of the review and is noted as such (see review 2, page 454). The additional information used to assist with coding was only from sources explicitly described in the publication being coded (i.e. using links or references in the published study; stated in the Methods section 3.3.6, page 65). This information has been added to the discussion section to make the sources of this additional information clearer (review 2 page 454). BCT taxonomy coding takes a conservative approach, and requires that the presence of BCTs is not inferred (see

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				Review 2, Appendix D: coding frames, page 488 in word document). Therefore if components of any intervention are not explicitly described they cannot be assumed to be present and coded based on the usual content of the intervention. In review 2, Methods section 3.3.6 it is noted that the 89-item version of the taxonomy used in review 2 has been superseded by an expanded 93 item taxonomy (in which one BCT was broken down into 5 component parts), highlighting the evolving nature of the taxonomy. We have added some text to make the evolving nature of the BCT taxonomy more explicit.
Motivational Interviewing Network of Trainers	General (external evidence 3)	25	We would suggest adding an MI competency framework to this section. A suitable framework is Cornwallis, E. *Competency Framework for Motivational Interviewing,* 2012. [Online] Available from: http://cornwallisassociates.co.uk/news.html	Thank you for informing us of this framework. The review includes an MI competency

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				framework from the Health Foundation (2011) 'Research scan: training professionals in motivational interviewing' (referenced on pages 14, 25, and 28 of review 3). The purpose of the frameworks and manuals was to provide overarching context within which the themes from the primary qualitative research could be reported. As such, the review did not aim to produce a comprehensive list of existing frameworks and manuals, rather to identify sufficient documents to develop descriptive categories and analytical themes for the thematic synthesis of the qualitative literature. Once there was saturation of the concepts (i.e. reviewing

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				further documents was not yielding further concepts) no further documents were included.
Motivational Interviewing Network of Trainers	General (external evidence 3)	50 *et seq*	We welcome the detail provided on relational processes in this part of the evidence review. We would recommend that the conclusions here are emphasised more in the final document (see note 3.37 p32 above).	Thank you for your comment but the PDG did not feel that the proposed change was necessary nor in line with the evidence considered.
Motivational Interviewing Network of Trainers	General (overall approach and conclusions)		In summary, although there is much to welcome in this document, we are concerned that the methodology of the evidence review had significant flaws which has led the authors to significantly understate the broader clinical imperative to engage patients as the foundation for any effort to promote behaviour change. We hope that this can be addressed in the final version.	Thank you for your comment. The PDG were content that the need for interventions to be delivered in a person centred way was clear in the guidance document.
National Centre for Smoking Cessation and Training	**General**		This guidance is timely and should be very useful in supporting local areas to plan how they commission and manage behaviour change interventions	Thank you.
National Centre for Smoking Cessation and Training	**Recommendation 2**: what action should they take / top bullet	7	To ensure the routine data collection is as useful as possible it is important that commissioners set outcome measures and stipulate a minimum data set with local and national reporting structures and the inclusion of exception reporting. Independent verification of data / performance is also crucial to ensure commissioned service providers meet minimum quality standards and data integrity (i.e. fraud prevention)	Thank you for your comments. Please see recommendation 17 on national support concerning what routine data should be collected. Independent evaluation

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				is highlighted as important in rec 4 and 16
National Centre for Smoking Cessation and Training	**Recommendation 4**: Who should take action / 1st bullet	8	Is this limited to local organisations or should this also apply to national services?	Please see recommendation for details – this is for local and national organisations.
National Centre for Smoking Cessation and Training	**Recommendation 4**: what action should they take / last bullet	9	This will need a minimum dataset and the guidance could include some suggestions or point to existing examples such as the NCSCT client record form http://www.ncsct.co.uk/publication_ncsct-stop-smoking-service-client-record-form.php	The PDG did not wish to be too prescriptive here, hence "if possible …." The NCSCT has been provided as an example. Please note this recommendation is now in recommendation 15 on monitoring.
National Centre for Smoking Cessation and Training	**Recommendation 5**: what action should they take / last bullet / 4th point	10	This should also include how those delivering the intervention will be deemed qualified to do so i.e. what will be the minimum qualification / training required?	Training requirements are provided in other recommendations.
National Centre for Smoking Cessation and Training	**Recommendation 5**: what action should they take / last bullet / 7th point	10	Also need to consider how quality can / would be measured	Quality is mentioned in this recommendation and the recommendation on evaluation addresses this.
National Centre for Smoking Cessation and Training	**Recommendation 6**: what action should they take / top of	11	As well as the training required, the level of assessment should be included in the design	Thank you for your comment. Recommendation 14 provides details on

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	the page / 2nd point			assessing training.
National Centre for Smoking Cessation and Training	**Recommendation 6**: what action should they take / 2nd bullet / 1st point	11	Suggest an example or a brief description of 'logic model' may be useful (even if as a footnote)	Thank you, this has been added to the glossary.
National Centre for Smoking Cessation and Training	**Recommendation 7**: what action should they take / 1st bullet	12	'if they wish' seems a bit too lenient and could be more directive – really VBA should be mandated as a minimum training requirement. This doesn't have to burdensome and e-learning provides an effective and time efficient mechanism of delivering this level of training. An example is the NCSCT's VBA online training http://www.ncsct-training.co.uk/player/play/VBA (although we realise this is already mentioned on page 18)	Thank you. This recommendation has been reworded. Please also see recommendation 13.
National Centre for Smoking Cessation and Training	**Recommendation 7**: what action should they take / 3rd bullet	12	Agree with this recommendation but how will staff know how to do this? This is one point that will definitely require practical resources and training	Thank you. Yes, training and resources would be required.
National Centre for Smoking Cessation and Training	**Recommendation 7**: what action should they take / last point	13	Not sure what a medium-intensity intervention would be for smoking?	Please see glossary definitions for intervention levels (note, terminology used has changed).
National Centre for Smoking Cessation and Training	**Recommendation 8**: what action should they take / 2nd bullet	13	What should trained practitioners do if a validated assessment tool isn't available?	For assessing most behaviours there are validated tools, though they may not have been assessed within a particular setting or population of interest.

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				We do not provide recommendations on what to do if a validated tool is not available.
National Centre for Smoking Cessation and Training	**Recommendation 9**: what action should they take / 2nd bullet	14	Would an example here be the recent NICE guidance on tobacco harm reduction? http://publications.nice.org.uk/tobacco-harm-reduction-approaches-to-smoking-ph45	The first bullet in the draft guidance would be relevant to the tobacco harm reduction guidance. i.e. THR should be an option for those who do not feel able to quit in one step
National Centre for Smoking Cessation and Training	**Recommendation 9**: what action should they take / 3rd bullet	14	There could potentially be a conflict here with the 'making every contact count' (MECC) agenda which promotes the importance of providing opportunistic advice at any time. As the MECC agenda is national policy and has been adopted by many local areas it would seem appropriate to refer to it I this guidance. Perhaps there is scope however to link it to teachable moments such as those currently highlighted in this point	Thank you for your comments. We have reviewed your concern and the PDG were content that the recommendation did not conflict with MECC.
National Centre for Smoking Cessation and Training	**Recommendation 10**: what action should they take / 1st bullet	15	Suggest that it would be worth making it clear at the beginning that these BCTs are the minimum required e.g. Behaviour-change interventions should, as a minimum, include the following techniques	Thank you for your comment.
National Centre for Smoking Cessation and Training	**Recommendation 10**: what action should they take / 1st bullet / 2nd point	15	Methods of validating behaviour changes should also be used where possible e.g. carbon monoxide monitoring	Thank you for your comment but this would not be appropriate in this recommendation.

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National Centre for Smoking Cessation and Training	**Recommendation 10**: what action should they take / 2nd bullet	15	Perhaps make it clear that whilst these BCTs should not limit an intervention they should be included i.e. form the basis before additional BCTs are added?	Thank you f or your comment. We think this is covered by 'Consider using other evidence-based behaviour change techniques that may also be effective. See NICE guidance on alcohol, diet, physical activity, sexual behaviour and smoking for details of specific techniques.' You can find other published NICE public health guidance at this link.
National Centre for Smoking Cessation and Training	**Recommendation 11**: what action should they take	16	Mention of the limited evidence regarding relapse prevention would be useful here This is another area where practical tools and training will be required if local implementation is to be possible	Thank you for your comment – however the issues around the evidence base are covered in the considerations section of the guidance and would not be appropriate here.
National Centre for Smoking Cessation and Training	**Recommendation 12**: what action should they take / top bullet	17	Training courses should also include a level of assessment Piloting of courses is also recommended to ensure they are going to be accessible for those it is intended for.	Thank you for your comment. The recommendation highlights the need for assessment and recommendation 14

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				provides further details.
National Centre for Smoking Cessation and Training	**Recommendation 14**: what action should they take / 1st bullet / 5th point	18	Not sure this point is clear – is it that practitioners should be aware of and know how to follow referral pathways?	Thank you for your comment. The recommendation has been re-worded for clarity.
National Centre for Smoking Cessation and Training	**Recommendation 14**: what action should they take / top bullet	19	This point isn't clear	It is not clear what aspect of the first bullet you are referring to, nor what changes are being suggested. If it is the first point, then this clearly cross-refers to another recommendation which highlights factors that need to be taken into account. Please note that all the recommendations in the guidance should be looked at together rather than in isolation; and recommendations are written in a way to avoid repeating information in other recommendations.
National Centre for Smoking Cessation and Training	**Recommendation 15**: what action should	20	An additional required skill is to 'deal with unhelpful group dynamics'	Thank you for your comments. These skills are highlighted as these

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	they take / 2nd bullet			are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence.
National Centre for Smoking Cessation and Training	**Recommendation 16**: what action should they take / 1st bullet	20	The latter half of this point is likely to be deemed too time intensive for many local areas. Again practical resources and guidance will be required.	Thank you for your comment. The PDGs intention here was to suggest this as best practice.
National Centre for Smoking Cessation and Training	**Recommendation 18**: what action should they take / final bullet	22	Ways of mandating and standardising minimum data returns should also be considered by HEE / PHE	NICE public health guidance aims to describe the role of organisations rather than name them explicitly in a recommendation in order to ensure they remain relevant regardless of whether organisations discontinue or change their names. Your comments concerning minimum

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				datasets are now in the recommendation.
National Obesity Forum	General		The National Obesity Forum (NOF) welcome the work done by NICE on behaviour change interventions and hope that the evidence base on effective interventions in this area will form part of the development of various pieces of guidance on obesity due to be published shortly.	Thank you for your comment.
National Obesity Forum	Recommendation 5	9	NOF believe that providers of weight management services could and should contribute to the development of behaviour change interventions in the areas of diet and physical activity. These providers often have excellent knowledge of the needs of the area in which they operate in and this knowledge needs to be exploited.	Thank you for your comment. This recommendation covers all Providers of behaviour-change programmes
National Obesity Forum	Recommendation 7	12	NOF agree that all healthcare professionals should be trained in some way to deliver behaviour change interventions. In this way they can make “Every Contact Count” and ensure that, even if a patient has not come to see a healthcare professional about obesity, the issue of the patient’s behaviour around food is still discussed.	Thank you for your comment.
National Obesity Forum	Recommendation 10	15	NOF agree that healthcare professionals should work with patients to set clear goals, develop action and coping plans, and provide social support.	Thank you for your comment.
National Obesity Forum	Recommendation 12	16	As touched upon above, NOF strongly believe that training should be provided for healthcare professionals so that they are aware of techniques that can be used to help change behaviours. It is important that these techniques are based on the latest evidence available.	Thank you for your comment.
National Obesity Forum	Recommendation 14	18	NOF strongly believe that GPs must be taught behaviour change techniques, in order to help them tackle obesity and overweight amongst the patients they	Thank you for your comment.

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			see. Too many GPs are not aware of what they can do help their patients or embarrassed to broach the subject, so further training is to be welcomed.	
Institute of Health and Society, Newcastle University	General		We recommend that in all sections with the header 'What action should they take', that each action point should be clear and measurable, so that research can be conducted to assess the degree to which each recommendation is being adopted. This may also facilitate the implementation of the actions by providers.	Thank you for your suggestion. It should be possible for organisations to monitor whether or not they are meeting each recommendation.
Institute of Health and Society, Newcastle University	Intro	1-2	It seems a false dichotomy to say that the behaviour change guidance is directed towards "individual-level" behaviour change interventions and not "community or population-level interventions to change behaviour". Ultimately, any intervention that changes behaviour must necessarily involve individuals and thus it is confusing to split individual-level from community and population level as it makes it seem as if the latter two somehow do not involve the individual level when they necessarily do if the end point is behaviour change. We suggest clarifying what is meant by individual-level, which will help practitioners to better appreciate the scope of the current guidance (particularly if the *content* of intervention could be distinguished from *mode of delivery* and *setting*). This is mentioned throughout the guidance and it would be helpful to elucidate.	Thank you for your comment. Definitions for these terms have been added to the glossary.
Institute of Health and Society, Newcastle University	Intro	2	What is meant by the guidance not covering "clinical" methods of changing behaviour?	The guidance does not cover clinical or pharmacological methods with no public health or health promotion element
Institute of Health and Society, Newcastle University	Recommendation 2	6 (and 7)	We agree that it would be ideal to ensure that behaviour change interventions aim to initiate and maintain change, but evidence for how to achieve the latter	Thank you for your comment. As you note,

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			is in its infancy and thus we question whether there are sufficient such interventions to make recommendations. We are also concerned how commissioners will be able to make a judgement as to whether a given intervention can achieve both initiation and maintenance of change without further evidence. It is also not clear how this recommendation differs from the recommendation on page 7 concerning effectiveness in the long term (more than 1 year), medium term (12 weeks-1year) and short term (6-12 weeks). This would benefit from clarification.	there is less evidence concerning maintaining behaviour change. We no longer specify a time period for maintenance and recommendation 4 provides further details concerning judging effectiveness and ensuring evaluation takes place.
Institute of Health and Society, Newcastle University	Recommendation 2 and Recommendation 4	7 9	We are in agreement that routine collection of behavioural data would be excellent step forward. However, we strongly suggest that if such a recommendation is made, that it should specify which measures should be employed and for which behaviours. Without a degree of standardisation, comparability and generalisability of measures used across the country, it will be difficult to analyse the data collected, which would be a missed opportunity.	Thank you for your comment. Recommendation 17 on national support makes recommendations concerning a minimum dataset but it is not the remit of this guidance to determine what this minimum dataset should be.
Institute of Health and Society, Newcastle University	Recommendation 3	8	We agree that it would be a good idea to disinvest in interventions or programmes if there is good evidence to suggest they are not effective, but it is not clear what sort of evidence would be required to make this decision (and for which outcomes).	Thank you for your comment. Please note that this guidance is not intended as a guide on how to undertake research.
Institute of Health and Society,	Recommendatio	12	It is not clear why such a focus is put on the intensity/duration of the	Thank you for your

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Newcastle University	n 7		intervention in this recommendation, and yet there is little to no mention of content. Describing an intervention as 'very brief' or 'brief' does not tell us anything about the content of that intervention and, as a consequence, makes it difficult to deliver with fidelity. Without describing the content of these interventions, there is a risk that ineffective or even counter-productive interventions are delivered simply because they are 'brief'. While there are good examples of very brief interventions whose content is clear, both characteristics are important for the intervention to be replicated. In sum: describing the duration of an intervention without its content does not lead to a helpful recommendation, as it is not clear what is being recommended. We suggest that the recommendation be amended to remove the specific focus on duration and give equal consideration to all intervention characteristics, as in other parts of the guidance.	comment. Further details about what an intervention entails are provide in the glossary. The focus is not specifically about length of time, it is just that these are the terms commonly used for different intervention levels. Other recommendations provide further details on intervention content.
Institute of Health and Society, Newcastle University	Recommendation 8 and 9, and section 6 (Capability, opportunity, motivation)	14; 36	We are not convinced by the sufficiency of the description of the 'capability, opportunity, motivation' model – particularly the motivation component, as it assumes an entirely reflective process in behaviour change. It is not clear why this particular set of constructs is highlighted above others. We do not disagree with the centrality of motivation, but it presumes a certain model of reflective, goal-directed behaviour change. The role of non-reflective, automatic processes that bypass motivation may also have a role to play. It may be hypothesised that there are some situations where the un-healthy behaviour is so difficult to pursue that what really matters is that there is an absence of motivation to pursue the alternative, rather than the presence of motivation to pursue the default. For example, in areas where tap water is naturally or artificially fluoridated, individuals can opt to only consume non-fluoridated bottled water to avoid the healthy behaviour. But this will require substantial motivation etc. Consuming fluoridated water will not, in this situation, require any specific level of motivation.	Thank you for your comment. The PDG reviewed evidence for this model (see expert paper 3). The guidance doesn't state that non-reflective processes are not important in explaining behaviour. For the purposes of an individual-level intervention the guidance is highlighting the need to assess and address capability, opportunity and motivation.

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Institute of Health and Society, Newcastle University	Recommendation 9	14	We urge caution in the wording of tailoring to individual motivation, as this may suggest consideration of stages of change, which should not be recommended given the lack of evidence to support stages of change. There is also a risk that depending on quality of the tool used to assess motivation and how it is used (e.g., one off motivation to change tools may not be appropriate if diurnal variability in within-person motivation is present), individuals may be denied an intervention. Meeting individuals' needs is centrally important, but we urge caution in how this is recommended within the guidance to avoid a situation where potentially helpful care is held back from people who may benefit on the basis of results on a readiness or motivation tool.	Thank you for your comment but tailoring is not synonymous with Stage of Change, which we do not recommend in this guidance. The recommendation is about providing care, not assessing whether someone should or should not receive an intervention.
Institute of Health and Society, Newcastle University	Recommendation 10	15	The term 'action plans' has a lay definition, which is not consistent with the scientific usage of the term in the behaviour change literature. We recommend adding 'of when, where and how to perform the behaviour' next to 'develop action plans'	These terms are all linked to a glossary definition.
Institute of Health and Society, Newcastle University	Recommendation 11	16	Action plans is used in a way that might be more appropriately described as coping plans.	These terms are all linked to a glossary definition.
Institute of Health and Society, Newcastle University	Recommendation 11	16	It is unclear what the theory and evidence-base is for many of the factors highlighted as important for maintenance of change and how these differ from factors relevant for initial behaviour change.	The evidence base for these specific techniques is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence; and is discussed in the considerations.
Institute of Health and Society,	Recommendatio	20	It is not clear why the selection of behaviour change techniques listed here	Thank you for your

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Newcastle University	n 15		have been singled out from others. Please provide further clarification.	comments. These skills are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence.
Institute of Health and Society, Newcastle University	Recommendations for research, section 4.2, 4.3, 4.4	34-35	These three recommendations suggest that variations in effectiveness of interventions according to socio-economic status should be explored. We agree with this, but further suggest that the scope for variations in effectiveness of interventions should be widened to include a range of socio-demographic factors, beyond just socio-economic status. Effectiveness may also vary according to age, gender, ethnicity, cultural background, etc of intervention recipients. We suggest that the recommendations should be amended to include other factors.	Thank you. This change has been made.
Institute of Health and Society, Newcastle University	Section 6 (Choice architecture intervention)	37	The definition of CAI given is a bit vague and non-specific. It is not clear what 'context' means in this description. We would suggest that all interventions involve changing the context in which a decision is made. For example, asking people to keep a food diary changes the context of diet-related decisions by making choices less private and less forgettable. Providing information on the harms of cigarette smoking to those who are unaware changes the information context of smoking.	Thank you for your comment. An example has been provided.

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			Offering a financial incentive contingent on behaviour change could be considered changing the context in which a decision about behaviour change is made. Reducing the availability of unhealthy products (e.g. cigarettes or unhealthy foods) could also be a change of context. However, we are not sure that all of these examples would be considered CAI. Overall, while we recognise that the guidance in its final form will not include recommendations related to CAIs, the description of CAIs as it stands lacks clarity and we would like to see the description amended.	
Optical Confederation & College of Optometrists	General		Optometrists and dispensing opticians are ideally placed in the community to deliver either 'brief interventions' or 'very brief interventions' to prevent sight loss or to deliver other important health messages. For example, we may be in a position to offer dietary advice to people with diabetes, or to discuss the importance of taking medication on a regular basis etc, and are certainly ideally placed to signpost community services or direct patients to appropriate professionals.	Thank you for this information. NICE public health guidance aims to describe the role of organisations rather than name them explicitly. Optometrists and dispensing opticians would be included under 'staff working in health, wellbeing and social care services who have contact with the general public'.
Optical Confederation & College of Optometrists	General		As optometrists carry out approximately 17.5 million sight tests a year in England (1), there is the potential for optometrists and dispensing opticians to do more to make 'every contact count' by expanding their role in health promotion. For example, they could provide smoking cessation or signpost to relevant services. Smoking is a major risk factor in age-related macular degeneration, which the biggest cause of blindness in the UK (2) and a principal risk factor in the development of cataracts (3). If resources and training were made available, these interventions could be delivered by health care professionals, such as optometrists and dispensing opticians, or referrals made to other primary care providers.	Thank you for this information. Please see response above.

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Optical Confederation & College of Optometrists	General		There were over 6.2m outpatient appointments for ophthalmology in 2011-12, the third busiest speciality (4). The vast bulk of these referrals come from community optometrists who detect sight threatening conditions through routine sight tests. Early detection and diagnosis are a key factor in patient outcomes, for example AMD requires an urgent referral from community optometrists to minimise sight loss. Certain ethnic groups and populations in areas of socio-economic deprivation are more at risk of poor eye health but less likely to seek treatment (5). Changing behaviour so that people, particularly those in high risk groups, have regular eye examinations would significantly improve the nation's eye health by lowering the level of undiagnosed eye conditions and by improving the outcomes of treatment.	Thank you for this information.
Optical Confederation & College of Optometrists	General		It would be helpful therefore if NICE and Public Health England could make clear the importance of early intervention by optometrists and dispensing opticians, especially with regard to the links between smoking and eye disease, and stress that opticians (via Local Optical Committees) should be included in local smoking cessation planning, commissioning and tendering, exercises to ensure optometrists and opticians can play their full role as health professionals in helping patients quit smoking and in getting their eyes tested regularly. **References:** (1) Optical Confederation (2011) Optics at a glance. http://www.opticalconfederation.org.uk/downloads/key-statistics/Optics%20at%20a%20Glance%202011.pdf (2) Bunce, C, Wormald, R. Leading causes of certification for blindness and partial sight in England and Wales. BMC Public Health. 2006; 6: 58.	Thank you for your comment. The PDG decided early in development that the guidance would not provide specific recommendations for a particular behaviour, but would instead focus on cross-cutting characteristics of effective interventions with individuals. For topic specific information, please refer to topic specific NICE public health guidance which is able to cover evidence on interventions for a particular behaviour in more detail.

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Optical Confederation & College of Optometrists			(3) Kelly, SP, et al (2004). Smoking and blindness: strong evidence for the link, but public awareness lags. *BMJ*; 328:537–8 (4) Hospital Episode Statistics: Outpatient, treatment speciality by attendance type: England 2011/2012, Health & Social Care Information Centre	Please note that we are unable to accept or review additional evidence at this stage.
Optical Confederation & College of Optometrists			(5) Dickey, H. Et al (2012) Utilisation of eye-care services: The effect of Scotland's free eye examination policy. Health Policy Volume 108, Issues 2–3, December 2012, Pages 286–293. Fraser et al (2001) Deprivation and late presentation of glaucoma: case-control study. *BMJ* 2001;322:639 doi:10.1136/bmj.322.7287.639 Saidkasimova, S et al (2009) Clinical science: Retinal detachment in Scotland is associated with affluence. *Br J Ophthalmo*l;93:1591-1594 doi:10.1136/bjo.2009.162347 Klein, R et al (2006). Prevalence of age-related macular degeneration in 4 racial/ethnic groups in the multi-ethnic study of atherosclerosis. *Ophthalmology* 113(3), 373-380 Diabetes UK (2004) *Diabetes in the UK*, www.diabetes.org.uk/Documents/Reports/in_the_UK_2004.doc Wadhwa, S & Higginbotham, E.J (2005), Ethnic differences in glaucoma: prevalence, management and outcome. *Current Opinion in Ophthalmology*, 16:101-106.	Please note that we are unable to accept or review additional evidence at this stage.
Optical Confederation & College	General		The College of Optometrists is the professional, scientific and examining body	Thank you for this

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of Optometrists			for optometry in the UK, working for the public benefit. The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical representative bodies: the Association of British Dispensing Opticians (ABDO); the Association of Contact Lens Manufacturers (ACLM); the Association of Optometrists (AOP); the Federation of Manufacturing Opticians (FMO) and the Federation of Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.	information.
Pharmacy Voice Ltd	General		Pharmacy Voice (PV) represents community pharmacy owners with the principal aim of enabling community pharmacy to fulfil its potential in playing an expanded role as a healthcare provider of choice in medicines optimisation, long term conditions and public health. Its founder members are the Association of Independent Multiple pharmacies (AIMp), the Company Chemists' Association (CCA) and the National Pharmacy Association (NPA).	Thank you for this background information on your organisation.
Pharmacy Voice Ltd	General		It has been demonstrated (in the Healthy Living Pharmacy pathfinder programme[1] and in the Wirral[2]) that pharmacy staff are well placed to make behaviour change interventions to people and the service is highly acceptable to the public. Community pharmacy staff see people when they are well in addition to when they are in poor health and are ideally placed to offer brief interventions. [1] *Evaluation of the healthy living pharmacy pathfinder work programme 2011 ---2012* http://www.npa.co.uk/Knowledge-Centre/Resources/Press-Releases/HLP1/HLP/ [2] *Understanding and optimising an identification/brief advice (IBA) service about alcohol in the community pharmacy setting*. September 2012 UCLAN, Liverpool JMU and NHS NW	Thank you for this information.
Pharmacy Voice Ltd	Recommendatio	P6	There are more pharmacies per head of population in areas of deprivation	Thank you for this

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	n 2 Health equity		than on average. By commissioning services from community pharmacies in areas of health inequality commissioners will be focussing on the target populations.	information. We envisage that these issues will be locally agreed and established based on need and resource.
Pharmacy Voice Ltd	Recommendation 3 Quality and effectiveness	P7	We support the need for evaluation to be included when a behaviour change service is commissioned. Evaluation should be consistent across all providers of the same service. Evaluation may demonstrate that an intervention works well in some settings and not others. A lack of extant evidence must not stifle innovation.	Thank you for your comment.
Pharmacy Voice Ltd	Recommendation 3 Quality and effectiveness	P7	We agree that for services with a proven value, quality assurance checking only is required.	Thank you for your comment.
Pharmacy Voice Ltd	Recommendation 4	P8	Commissioners need to bear in mind that community pharmacies are independent providers to the NHS; on average, over 90% of their income comes from the NHS. They include corporate entities, SMEs and micro businesses. Commissioners may need to provide appropriate support in the commissioning processes if services are to be commissioned on a sustainable basis and to encourage pharmacy owners to invest in service delivery, including the development of staff.	Thank you for your comment
Pharmacy Voice Ltd	Recommendation 6	P10	Consideration needs to be given in the design of behavioural change programmes to how employees are engaged and have ownership of delivery. The Macleod[3] report findings about the importance of employee engagement	Thank you for this information. Co-production is recommended in recommendation 6.

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			has been validated in the Healthy Living Pharmacy programme, where 80% of managers describe their staff as more productive following implementation and over 90% describe the programme as worthwhile as a staff development tool. There are many anecdotal examples of where Health Champions within the HLP framework have changed their own behaviours after undergoing the programme.	Please note that we are unable to accept or review additional evidence at this stage.
Pharmacy Voice Ltd	Recommendation 7	P12	Community pharmacy staff are ideally placed to offer brief interventions – the alcohol brief interventions delivered on the Wirral, which identified a greater than anticipated number of people with risky drinking behaviours, signposting them to appropriate support, has been replicated elsewhere in alcohol and other services[4]	Thank you for your comment.
Pharmacy Voice Ltd			[1] **Engaging for Success:** enhancing performance through employee engagement A report to Government by David MacLeod and Nita Clarke 2010 www.berr.gov.uk/files/file52215.pdf [2] Evaluation of the health Living Pharmacy pathfinder work programme 2011-2012 http://www.npa.co.uk/Knowledge-Centre/Resources/Press-Releases/HLP1/HLP/	Thank you.
Pharmacy Voice Ltd	Recommendation 7	P12	The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services to meet local need, improving the health and wellbeing of a local population and helping to reduce health inequalities. Different levels of the framework, which is underpinned by	Thank you for this background information.

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			the key enablers of workforce development, engagement and environment (premises), can be used for different level interventions. In an HLP, the team proactively promotes health and wellbeing by offering advice on a range of health issues such as smoking, physical activity, sexual health, healthy eating and alcohol use. In the initiator programme in Portsmouth, over 10,000 individuals have received brief advice on safe alcohol consumption; with 36% at increased risk and10% at high risk.	
Pharmacy Voice Ltd	Recommendation 7	P12	To maximise the potential of such interventions, community pharmacy needs to be linked effectively to those providing appropriate services. Direct referral, if appropriate, would improve follow-up and reduce duplication across the service.	Thank you. This level of information would not be provided in this recommendation.
Pharmacy Voice Ltd	Recommendation 8	P13	Health Champions (there are over 1,500 in HLPs) and Health Trainers are well placed to assess clients in the community.	Thank you. Health champions and trainers would be included under 'who should take action': Providers of behaviour change programmes and interventions, trained behaviour change practitioners.
Pharmacy Voice Ltd	Recommendation 12	P16	NHS Yorkshire & Humber have developed a useful framework for public health competencies in the health workforce[5] to making every contact count which could be looked at (no need to reinvent the wheel). HLP requirements have been mapped over.	Thank you for your comment. The Yorkshire & Humber Competence Framework was in the evidence reviewed by the PDG (see Expert

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				paper 11 and Evidence review 3) and informed the recommendation on competences (12).
Pharmacy Voice Ltd			[3] ***Prevention and Lifestyle Behaviour Change Karen Payne Public Health Workforce Lead*** ***Faculty of Health and Wellbeing, Sheffield Hallam University*** ***http://www.yorksandhumber.nhs.uk/document.php?o=5021***	Thank you.
Pharmacy Voice Ltd	Recommendation 15	P19	Clarity of role is important; training should include why behaviour change is important, and include questioning skills designed to engage client and strategies to roll with resistance.	Thank you for your comments. These skills are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence.
Pharmacy Voice Ltd	Recommendation 16	P20	We agree; ideally there should be a regular assessment of a practitioner's ability to deliver change interventions, but we are not clear who will deliver this. For regulated professionals there may be a role here for revalidation, but Health Champions and other staff working in pharmacies may currently be delivering in non-regulated roles.	Thank you for your comment. The recommendations have been redrafted and it should now be clear who is expected to undertake assessment and feedback.
Pharmacy Voice Ltd	Delivery 3.27	30	We have already pointed out that community pharmacies can be found in	Thank you. Please see

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			numbers in areas of deprivation, so they may be well placed to deliver interventions to reduce health inequalities and bridge the gap for those people who do not regularly see or have access to a GP.	above responses.
Pharmacy Voice Ltd	Delivery 3.27	30	Commissioners may wish to focus service delivery on reducing health inequalities, but risky alcohol consumption is not restricted to populations in areas of health inequality. Pharmacy interventions such as the use of alcohol scratch cards have been shown to be effective at engaging a wide range of people in different demographies and to have conversations about their drinking habits.	Thank you. The recommendations advocate a proportional universalism approach.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	General		The draft guidance recognizes that there is a need for evidence-based, cost effective behaviour-change interventions for smoking. Despite the well-known health effects of tobacco use, many people continue to smoke and use other tobacco products. Providing smokers with acceptable alternative options – whether nicotine only or products containing tobacco – that have a biological impact comparable or approaching that of cessation is, we believe, an important element of a harm reduction policy. Indeed, there is increasing recognition – including among representatives of the Royal College of Physicians and the UK Centre for Tobacco Control Studies – that smokers who are unwilling to or unsuccessful in quitting smoking should have access to and should be encouraged to use reduced harm alternatives to conventional cigarettes. (HM Government, A Smokefree Future: A Comprehensive Tobacco Control Strategy for England (2010); Royal College of Physicians Tobacco Advisory Group, Harm Reduction In Nicotine Addiction: Helping People Who Can't Quit, 223 (2007).)	Thank you for your comment. Please note that there is other NICE guidance specifically in relation to tobacco use and cessation – you can find a full list of NICE public health guidance at the hyperlink embedded in this sentence.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	General		One such intervention would be to encourage smokers who do not want to quit (or who cannot quit) to switch to nicotine-containing products that have been appropriately regulated. Regulation should allow these products to be widely available while ensuring that they are supported by safety and quality	Thank you for your comment. Please note that there is other NICE guidance specifically in

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			standards and scientific evidence, including data that shows that the use of these products results in biological responses comparable with cessation.	relation to tobacco use and cessation – see NICE public health guidance
Philip Morris Limited and its parent company, Philip Morris International (PMI)	General		Another option is reduced risk tobacco products, such as the "modified risk tobacco products" recognized by the US Congress and regulated by the US FDA. PMI believes that reduced risk tobacco products are likely to be more acceptable substitutes for conventional cigarettes to a wider group of smokers than current alternatives including e-cigarettes. A product can only reduce harm if it is used and accepted by smokers. Tobacco provides the sensorial impact that provides smoker satisfaction. This in turn will reduce the amount of dual use (smokers who use the reduced risk product and conventional cigarettes concurrently) and relapse. In addition, we have seen that the tobacco in the product significantly reduces the amount of interest in the product from non-smokers, thus reducing the likelihood of initiation The Institute should anticipate that these novel tobacco products may play a more significant role in future behaviour-change interventions.	Thank you for your comment. Please note that there is other NICE guidance specifically in relation to tobacco use and cessation.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	General		In fact a number of public health authorities have recognized, reduced-risk products will only be effective substitutes for cigarettes if they are widely accepted by adult smokers. (Cobb, C., Weaver, M., Eissenberg, T., "Evaluating the Acute Effects of Oral, Non-Combustible Potential Reduced Exposure Products Marketed to Smokers," 19 TOBACCO CONTROL 367-73 (2010); see also Le Houezec, J., Mcneill, A., and Britton, J., "Tobacco, Nicotine and Harm Reduction," 30(2) DRUG & ALCOHOL REVIEW 119-23 (2011).) A product which "mimics the pharmacokinetic nicotine delivery characteristic of the cigarette" without exposing smokers to many harmful or potentially harmful smoke constituents (UK Centre for Tobacco Control	Thank you for your comment. Please note that there is other NICE guidance specifically in relation to tobacco use and cessation. We are unable to look at additional evidence at this stage in guidance development.

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			Studies, Response to Consultation "MLX 364: Regulation of Nicotine Containing Products," available at: http://www.mhra.gov.uk/home/groups/es-policy/documents/publication/con102949.pdf.) may have the greatest potential.	
Philip Morris Limited and its parent company, Philip Morris International (PMI)	General		PMI has recognized this and is developing and assessing a range of potential reduced risk products, including products that do not contain tobacco as well as tobacco-containing products. On the latter, our approach is to eliminate combustion and generate a nicotine-containing aerosol at low temperatures – much like e-cigarettes do. Unlike e-cigarettes, the nicotine in the aerosol comes directly from a tobacco substrate, providing adult smokers with a product we believe they will accept as a substitute for conventional cigarettes.	Thank you for your comment. Please note that there is other NICE guidance specifically in relation to tobacco use and cessation.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	General		Underlying our product development is an extensive research program that is intended to provide rigorous substantiation of the risk reduction potential of the products and to address the critical questions of their impact on public health including an innovative perception and behavioural program and post-marketing surveillance. We are also testing our products to ensure that smokers who switch to them will not be exposed to any new hazards when compared to continued smoking of conventional cigarettes. The evidence from PMI's research to date on the risk reduction potential of our products is encouraging. Importantly, the results of PMI's behavioural research provides evidence that communicating the potential harm reduction benefits of such products is essential for the effectiveness of any such intervention.	Thank you for your comment. Please note that there is other NICE guidance specifically in relation to tobacco use and cessation.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 2 - Commissioning	6-7	The draft guidance recommends that behaviour-change interventions should aim to both initiate and maintain positive behaviour-change. PMI agrees that only those interventions proven to be effective over the short-, medium- and	Thank you for your comment. Evidence not subjected to our review

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	behaviour-change programmes: principles		long-term should be commissioned. NRTs, used with or without counselling, have not meaningfully improved smokers' long-term chances of successfully quitting smoking. (HM Government, A Smokefree Future: A Comprehensive Tobacco Control Strategy For England, 11 (2010) (noting that fewer than 3% of smokers succeed in quitting each year). See, e.g., Alpert, H., Connolly, G. and Biener, L., "A Prospective Cohort Study Challenging the Effectiveness of Population-Based Medical/Intervention for Smoking Cessation," Tobacco Control (2012); see also Ferguson, J. *et al*., "Effect of Offering Different Levels of Support and Free Nicotine Replacement Therapy via an English National Telephone Quitline: Randomised Controlled Trial," BMJ 344:e1696 (23 March 2012).)	process can not be included, or looked at by the PDG at this stage in the guidance development.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 2 - Commissioning behaviour-change programmes: principles	6-7	As mentioned above, PMI's research suggests that switching from conventional cigarettes to our novel reduced risk tobacco products has the potential to reduce the risk associated with smoking in line with smoking cessation. For example, a short-term clinical study found that an earlier version of one of our reduced risk products reduced levels of the measured biomarkers of harmful or potentially harmful constituent (HPHC) exposures to levels similar to those found in subjects who quit smoking (Study YVD-CS01-EU, ClinicalTrials.gov, Identifier NCT00812279). Further, data from a 12-month long-term clinical trial showed favourable biological responses in subjects that switched from conventional cigarettes to an earlier version of another one of our novel reduced risk products *i.e.*, increased levels in high-density lipoprotein levels and decreases in white blood cell counts (reflecting decreased inflammation) and 11-dehydro-TXB2 (which reflects decreased platelet aggregation).	Thank you for your comment.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 9 - Delivery: meeting individual need	14	The draft recommendation recognises that interventions must be tailored to an individual's need *i.e.,* a person's capability and motivation to change. This is particularly important in relation to smoking where some individuals are unwilling or unable to quit. In such cases, we believe that interventions should	Thank you for your comment.

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			support a person to switch from conventional cigarettes to substantiated reduced risk products, whilst still communicating that cessation is the best option.	
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 9 - Delivery: meeting individual need	14	Individuals need to understand the likely health benefits for them if they are to be successful in changing their smoking behaviour, *i.e.,* if they are to quit or switch to a substantiated reduced risk alternative. It can be challenging to communicate the relative risk of a reduced risk product compared to a conventional cigarette, while still communicating that cessation is the best way for a person to reduce their risk of smoking-related disease. Many smokers fail to appreciate the relative risks of different tobacco products and of nicotine. For example, in the UK one third of adult smokers are concerned that NRTs are just as harmful as cigarettes (Borland, R., McNeill, A., O'Connor, R., Cummings, M., "Trends in Beliefs About the Harmfulness and Use of Stop-Smoking Medications and Smokeless Tobacco Products Among Cigarettes Smokers: Findings from the ITC Four-Country Survey," 8 Harm Reduction Journal, art. 21 (2011)). Further, a significant minority of smokers in England believe that the use of NRTs for a year or more is harmful (Black, A., Beard, E., Brown, J., Fidler J., and West, R. Beliefs about the harms of long-term use of nicotine replacement therapy: perceptions of smokers in England. Addiction 107(11) 2037-42 (2012)).	Thank you for your comment.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 9 - Delivery: meeting individual need	14	Significant effort needs to be made to raise smokers' awareness and understanding of the health benefits of cessation and switching from conventional cigarettes to reduced risk alternative products. Qualitative and quantitative research methods should be used to develop and validate balanced messages that are correctly understood by smokers.	Thank you for your comment.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 10 - Behaviour-change	15	PMI welcomes the recommendation not to limit individual-level interventions to the list of behaviour-change techniques set out in the draft guidance. The Institute should continue to assess and consider novel interventions, including the use of reduced risk products with behaviour-change techniques, provided	Thank you for your comment.

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	techniques		that the products have been scientifically substantiated to reduce the risk of smoking or the intervention is accompanied by an adequately powered controlled evaluation.	
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 15 - Training for behaviour-change practitioners: the detail	19	The psychological factors underpinning smoking are complex and interventions are likely to be more effective if they replicate the cigarette smoking experience. For example, many NRTs fail to replicate the sensory experience and ritual of smoking; as a result, many smokers do not accept them. An additional limitation of existing products is "the fact that no available licensed nicotine-containing product mimics the pharmacokinetic nicotine delivery characteristics of the cigarette." (UK Centre for Tobacco Control Studies, Response to Consultation "MLX 364: Regulation of Nicotine Containing Products," available at: http://www.mhra.gov.uk/home/groups/es-policy/documents/publication/con102949.pdf.) Novel reduced risk products that replicate the sensory experience and ritual of conventional cigarettes while generating significantly fewer HPHCs found in smoke are therefore more likely to be acceptable substitutes for conventional cigarettes than current alternatives, for many people. Behaviour-change interventions that aim to educate individuals of the health benefits of such products have the potential to benefit public health.	Thank you for your comments. The skills highlighted in this recommendation are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked document (previously **in section 9** of the draft guidance) which links recommendations to the evidence.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 15 - Training for behaviour-change practitioners: the detail	19	Effective risk/benefit communications about reduced risk products must play a crucial role in helping smokers understand and ultimately accept these products and switch to them from conventional cigarettes. Smokers need interventions to provide clear, non-misleading information about the benefits of using a reduced risk product instead of conventional cigarettes in order to enable them to make a positive choice to change their behaviour. Indeed, smokers are in large part interested in switching to reduced risk products, but fail to do so due to misinformation (Heavner, K.K., Rosenberg, Z., and Philips C.V. "Survey of smokers' reasons for not switching to safer	Please see response above. Also please note that the PDG agreed early on in development that this guidance would not provide specific recommendations for a particular behaviour. For this information, please refer to topic

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			sources of nicotine and their willingness to so in the future." Harm Reduction Journal 6:14 (2009)).	specific NICE public health guidancewhich is able to cover evidence on interventions for a particular behaviour in more detail.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 15 - Training for behaviour-change practitioners: the detail	19	The introduction of reduced risk products onto the market without relative risk messaging will not contribute to an individual's understanding of relative harms, which is a necessary precursor to encourage and motivate smokers to change their smoking behaviour. For example, only one in six US and Canadian smokers believe that smokeless products are less harmful than conventional cigarettes despite those products being on the market (Borland, R., McNeill, A., O'Connor, R., Cummings, M., "Trends in Beliefs About the Harmfulness and Use of Stop-Smoking Medications and Smokeless Tobacco Products Among Cigarettes Smokers: Findings from the ITC Four-Country Survey," 8 Harm Reduction Journal, art. 21 (2011)).	Please see above responses.
Philip Morris Limited and its parent company, Philip Morris International (PMI)	Recommendation 17 - Evaluation of behaviour-change programmes	21	PMI supports the recommendation that interventions should be evidence-based and evaluated using objective, validated measures of behaviour-change outcomes. Qualitative and quantitative measures are needed to determine if a smoking intervention is effective.	Thank you for your comment. We have added that evaluation should include 'rigorous qualitative assessments to evaluate how well interventions will work in practice and how acceptable they are to services users and practitioners'
Philip Morris Limited and its parent company, Philip Morris	Section 4 - Recommendatio	34	We note that no recommendations concerning choice architecture interventions were made due to a lack of publicly available evidence on the	Thank you for this information. When

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International (PMI)	ns for research		effectiveness of this approach. PMI supports the research recommendations aimed at increasing the evidence-base on nudges and is currently developing a comprehensive programme to study consumer perception and behaviour in relation to smoking and the use of novel reduced harm products. PMI is developing a comprehensive programme to study adult consumer perception and behaviour intention. We wish to share on a **confidential basis** the design and results of this research to aid the Institute's understanding of smoking and behaviour-change messaging, in particular the nudges that would encourage individuals to switch from conventional cigarettes to reduced harm alternatives.	guidance is in development there is a call for evidence and we encourage you to submit work to this. Submissions can be made on an 'in confidence' basis.
Public Health England	General	n/a	We support the draft guidance. It contains sound principles which would have a positive impact if they are adhered to in commissioning and implementing interventions. The recommendations about training for example are particularly useful. The guidelines could also support our work to increase the reach of Information and brief advice about alcohol.	Thank you for your comment.
Public Health England	General		PHE welcomes the update of the guidance and the draft has a lot of useful content.	Thank you for your comment.
Public Health England	General		We feel that the draft lacks a lot of the Local Government/post reforms language specificity that would be helpful to include – e.g. Health and Well Being Boards as a key audience	Thank you for your comment. This does not appear to be a general view shared by local government audiences in this stakeholder consultation nor during the fieldwork. There are

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				several PDG members on this guidance that work in/with local authorities. NICE public health guidance now aims to describe the role of organisations rather than name them explicitly in a recommendation in order to ensure they remain relevant regardless of whether organisations discontinue or change their names.
Public Health England	General		Given the decision to exclude 'choice architecture' from the guidance the title is inaccurate. This is guidance about commissioning one-to-one behavioural support programmes. Calling it behaviour change guidance without considering a wider range of policy levers could confuse/disappoint practitioners	Thank you for your comment. The guidance title has been changed to Behaviour change: Individual approached.
Public Health England	General		The recommendations are not structured in a way that makes them easy to use. There are 76 recommendations under 18 broad groupings. We think it would be helpful for the recommendations to follow the 'pyramid thinking' model where a headline recommendation such as 'integrated commissioning strategy' is then expanded upon. Additionally, frontline practitioners will look for the 'checklist' that they should organise against and it would be helpful and straightforward for NICE to provide them in this format (this could be a straightforward excel or web based filter that accompanies the report).	The recommendations have been re-ordered. Please note that recommendations will also be available within NICE pathways, in which all recommendations can be seen together under sub-headings. The guidance follows a template. We do not

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				provide checklists in the guidance.
Public Health England	General		There is a face to face bias to the recommendations that underplays digital interventions - it may be helpful to mention digital options more than at present.	Thank you for your comment. The evidence reviews did not identify many studies on digital options, hence specific recommendations on using these could not be made. We have however added to recommendation 7 'Consider delivering an intervention remotely (or providing remote follow-up) if there is evidence that this is an effective way of changing behaviour. For example, use the telephone, text messaging, apps or the internet.'
Public Health England	General		In reality, very few services will be being commissioned afresh. Given this there is a disappointing lack encouragement for the optimisation of existing interventions. There is a clear evidence base that simple changes to the uptake pathway, such as the introduction of of SMS reminders, can significantly increase uptake. Collecting this data in an a/b / cost-benefit model is of enormous utility but is exceedingly rare within the sector. We would like to see an additional recommendation in this area.	Thank you for your comment. The evidence reviews did not identify these findings. Please note that this guidance is not intended as a guide on how to undertake research.

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Public Health England	Rec 8 Client Assessment	13	We recognise that "different alcohol screening tools are used in prisons and in accident and emergency departments " but we would recommend that AUDIT based screening tools should be used in all settings.	Thank you for your comment. As the PDG have not reviewed all possible assessment tools, we are not in a position to recommend a specific tool in this guidance. In addition, it was decided that this guidance would not provide specific recommendations for a particular behaviour. For this information, readers should refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in more detail.
Public Health England	Rec 10 Behavioural Change Techniques	15	This item might benefit from mentioning FRAMES, which is an acronym summarising the components of a brief intervention. This is set out in NICE public health guidance 24: • Feedback (on the client's risk of having alcohol problems), • Responsibility (change is the client's responsibility) • Advice (provision of clear advice when requested) • Menu (what are the options for change?), • Empathy (an approach that is warm, reflective and understanding)	Thank you for your comments. These techniques are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific techniques is

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			and • Self-efficacy (optimism about the behaviour change). It may be worth mentioning FRAMES in the guidance and expanding a little in the glossary, as is done in PHG24.	highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence; and is discussed in the considerations.
Public Health England	Recommendations	Page 19	Recommendation 18 potentially underplays the role of PHE. Would it be helpful to add in a section about supporting development and capturing of the evidence and innovation through a sector lead improvement approach?	Thank you for your comment. We have highlighted supporting implementation as a role for national organisations. You will note that this guidance is now in a new format. NICE public health guidance now aims to describe the role of organisations rather than name them explicitly in a recommendation in order to ensure they remain relevant regardless of whether organisations discontinue or change their names.
Public Health England	6. Glossary – Alcohol: recommended weekly limits.	35	The document discusses government recommended weekly limits. At the moment (under review by the CMO), DH does not endorse 'weekly' limits, but instead emphasises 'daily' limits. Men should not regularly drink more than 3-4 units on a daily basis and women should not regularly drink more than 2-3 units on a regular basis.	Thank you for your comment. Daily limits are now provided, as is advice to look for the latest guidance on alcohol limits.

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Public Health England	6. Glossary – Alcohol: recommended weekly limits.	35	Instead of pointing people to the Drinkaware website, the guidance should point people to Change 4 Life http://www.nhs.uk/change4life/pages/alcohol-lower-risk-guidelines-units.aspx	Thank you. This change has been made.
Royal College of General Practitioners	Draft recommendations whose health will benefit And 3.4 on p 25	4	Although the remit is for people over 16 it would be beneficial to clarify that the approaches, whilst not being targeted at younger people, may still be relevant and appropriate to them. Otherwise there risks chance of interpreting that these approaches are not suitable for those under 16.	Thank you for your comment but as we have not reviewed the evidence for under 16s, we cannot state that these are suitable (whether or not they are).
Royal College of General Practitioners	Top of page	7	Where routine data collection is recommended, it would be worth including weight measurement with the examples of smoking and alcohol because, although weight measurement is a contentious issue in some ways, recommending that it is recorded in the context of behaviour change discussions may help to normalise the step amongst both clinicians and the public.	Thank you for your comment. We try to limit the number of examples provided. This recommendation no longer provides any example behaviours but highlights as an example 'behaviours covered by the Public Health Outcomes Framework'. Please note that it was decided that this guidance would not provide specific recommendations for a particular behaviour.

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Royal College of General Practitioners	Recommendation 10 -actions	15	There is insufficient focus on recognising the need for participants to be involved in setting their own goals and for goals to be tailored to the individual. This is particularly relevant to people with disability. It would be useful to highlight this fact as providers might perceive 'success' as needing to meet ideals – and then leave individuals feeling as though they have failed. For example, someone who is not ready to aim for 5-10% weight reduction target might still aim for weight constancy – a worthwhile goal in itself in someone who had steadily gained weight. It is for the individual to set this goal with appropriate support.	Thank you for your comment. The guidance highlights the importance of taking a person-centred approach. The introduction to this guidance now states that 'The recommendations should be implemented together, using a person-centred approach'.
Royal College of General Practitioners	General		I would like to reiterate the need to avoid reliance on simplistic BMI change outcome measures for evaluating weight management programmes: BMI is one of the hardest indicators to change, but engagement in a healthy lifestyle programme may have many other benefits to health, such as dietary quality, reduced salt intake, improved fitness, reduced falls risk, lower blood pressure, improved glycaemic control etc. If there is sole reliance on BMI change, then the wider and varied – albeit difficult to measure – health benefits will be unrecognised and participants may even perceive failure when in fact they had gained a series of other less visible health gains. This facet of health gain is important to understand both by practitioners and by participants.	Thank you for your comment. We have not made recommendations to use BMI change as an outcome measure.
Royal College of General Practitioners	Brief intervention	36	It would be useful to have some sort of definition of what is meant by a brief intervention. Does this mean an evaluated brief intervention or a 'quick chat'? This would be important for the research agenda as there are limited examples of evaluated brief interventions on weight management at present. Further expansion on this may help practitioners to recognise if they are giving brief advice about prevention approaches or treatment approaches as the evidence base not the same for both.	Thank you for your comment. 'brief intervention' is defined in the glossary section of the guidance: 'A brief intervention involves oral discussion, negotiation or encouragement, with or without written or other support or follow-

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				up. It may also involve a referral for further interventions, directing people to other options, or more intensive support. Brief interventions can be delivered by anyone who is trained in the necessary skills and knowledge. These interventions are often carried out when the opportunity arises, typically taking no more than a few minutes for basic advice.'
Royal College of Nursing	General	General	The Royal College of Nursing welcomes proposals to update the Behavioural Change Public Health Guidance.	Thank you.
Royal College of Nursing	General	General	The document seems comprehensive. However, it would be helpful for the final guidance to be written in plain English so that it does not sound jargonistic and health orientated.	Thank you for your comment. All NICE guidance goes through an editing process to ensure guidance is written in as plain English as possible. It is however sometime necessary to use technical terms, and where we do we try to

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				ensure a glossary written in plain English is provided.
Royal College of Nursing	General	General	With respect to equality issues, we would suggest that this should specifically mention fluctuating conditions, mental health, those with learning disabilities or people with risky behaviours and also access/transportation. Also Children and young people who have specific access issues	Thank you for your comment. Children and young people are out of scope. Changes throughout have been made to ensure equality issues are addressed.
Royal College of Nursing	General	General	The document seems rather health orientated and to be aimed predominantly at the statutory services. Since many services for behavioural change are delivered by small voluntary organisations, it is important to reflect this in the final guidance. It should also reflect the integrated care agenda and those from social services Also, some of the recommendations felt still very much like telling people what they should do rather than working in partnership with them.	Thank you for your comment. The guidance section on 'who should take action' covers these organisations. The guidance highlights the importance of taking a person-centred approach. The introduction to this guidance now states that 'The recommendations should be implemented together, using a person-centred approach'. Recommendations also highlight the importance of co-production.
Royal College of Nursing	General	General	The whole document is very aspirational and certainly for many organisations could be very challenging to meet the recommendations. We agree that motivational interviewing techniques can support this, for example the use of Making Every Contact Count initiative as a way to raise issues of Health and Wellbeing in an opportunistic way.	Thank you for your comments.

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Royal College of Nursing	General	General	Much of the document talked about providing current statistics to inform commissioning but did not seem to suggest what should be collected, how it would be measured, what the baseline is etc. Commissioning for outcomes not numbers of people offered a service would be helpful. There probably needs to be a range of indicators to measure numbers attending training and numbers of those who feel more able to ask the difficult question alongside numbers asked about lifestyle, smoking, intention to change?	Thank you for your comment. We do not agree that the focus is on numbers, it is on ensuring commissioned interventions are effective, which would require information on outcomes.
Slimming World	Recommendation 1	5	Suggest an extra bullet is added to the 'what action should they take' section to include engagement with providers and users e.g. Engage with providers and service users to inform policy and strategy development.	Thank you for your suggestion. The following has been added: 'Work with the local community to develop the strategy (see Community engagement, NICE public health guidance 9).'
Slimming World	Recommendation 3	7	The first bullet in the 'what action should they take' section states that existing interventions should be assessed on effectiveness and cost effectiveness – what is the benchmark for this? Suggest this is added in to make it clear to commissioners.	Please note that this guidance is not intended as a guide on how to undertake research.
Slimming World	Recommendation 3	7	The second bullet in the 'what action should they take' section talks about evaluation. Suggest this makes reference to recommendation 17 which goes into more detail.	Thank you for your suggestion. Please note that all the recommendations in the

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				guidance should be looked at together rather than in isolation. It is a balancing act how much cross-referencing to other recommendations is made. We try and limit cross-referencing to where it is absolutely needed.
Slimming World	Recommendation 3	8	The fifth bullet in the 'what action should they take' section states that new un-evidenced services should be commissioned only if accompanied by a thorough evaluation. A concern with this is that it will hinder innovation, especially among small providers as they just wouldn't have the funds to do this.	Thank you for your comment. It is recognised this may be challenging, however, not evaluating an innovative service may result in it not gaining future funding due to lack of evidence.
Slimming World	Recommendation 4	8	Suggest this recommendation moves along two places after the recommendations on planning and designing. Currently it feels a bit odd to look at organisational support before recommendations 5 and 6.	The recommendations have been re-ordered. Organisational support remains a recommendation provided early on in the guidance.
Slimming World	Recommendation 4	8	Looking at the first bullet point in 'what action should they take' we found this quite confusing. Is the recommendation suggesting that behaviour change support should be available for all staff at an organisation who delivers behaviour change programmes or just for those people delivering the programme? Could this be made clearer?	Thank you for your comment. The recommendation has been edited to make this clearer.
Slimming World	Recommendation 4	8	Looking at the third bullet point in 'what action should they take' we support this point but feel it could be stronger. We agree that staff should be	Thank you for your comment but we do not

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			supportive, motivating and empathetic but also feel that they should have been recruited on this basis if they are to be delivering behaviour change programmes and suggest that a bullet on recruitment is added in.	feel this is appropriate as we do not know of, nor have the PDG looked at evidence concerning how you could judge these attributes. In addition these may be attributes that can be developed over time.
Slimming World	Recommendation 4	9	Looking at the sixth bullet point in 'what action should they take', what data would need to be collected on behaviours? Could this be clearer?	The behaviours would depend on the behaviour change intervention and so specific details are not given. An example dataset is provided: 'For an example of what could be collected on smoking, see the National Centre for Smoking Cessation and Training stop smoking service client record form.'
Slimming World	Recommendation 5	9	Intervention designers and service developers are mentioned in recommendation 5 and 6 and then only intervention designers are mentioned in some of the following recommendations. Should service developers be alongside intervention designers consistently?	Thank you for your comment. Recommendations are not necessarily always relevant to providers if they are also relevant to intervention designers.

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Slimming World	Recommendation 5	9	Looking at the first bullet point in 'what action should they take' we suggest that individuals the service is going to be aimed at are added to the example stakeholders.	Thank you. This has been added.
Slimming World	Recommendation 5	10	Looking at the last bullet point in 'what action should they take' under intervention characteristics - it is vital that a programme is flexible to meet individual needs (i.e. sessions available different days of the week and at different times) and we suggest this is acknowledged.	Thanks you for your comment. We agree this is important however this recommendation sets out the broad issues that need to be considered – this should be addressed when taking into consideration 'who will deliver it, where and when'. Please note that all the recommendations in the guidance should be looked at together rather than in isolation. Recommendation 8 specifically addresses meeting individuals'' needs.
Slimming World	Recommendation 6	11	The recommendation suggests that manuals should be developed and include details of the programme. Would this also apply for an existing programme? How much detail would be required in the manual? If lots of detail would be required, and it had to be made publicly available then this wouldn't be viable for a commercial programme. It suggests that detail should be given to allow replication of components and this seems unrealistic, this risks an assumption being made that you can learn to deliver a component via a manual without the need for training which is unlikely to result in people being well skilled.	Thank you for your comment. The details required of a manual are provided in the recommendation. Yes, existing programmes should provide details. We have added 'provide

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				copyright details and 'training before use' requirements' in manuals.
Slimming World	Recommendation 7	12	This recommendation is confusing as it implies that NHS staff should ensure they are offered training yet it is likely to be their management that need to ensure this. Suggest 'Managers' is inserted before each bullet in the 'who should take action' section e.g. Managers of NHS and social care professionals.	Please note that there have been considerable changes to this recommendation and it no longer discusses training needs as these are covered elsewhere.
Slimming World	Recommendation 7	12	Looking at the third bullet point under 'what action should they take', this is currently not an action. Does it mean all staff need training so they can deliver interventions or does it mean they should already be doing it. Could this be made clearer?	Please see response above.
Slimming World	Recommendation 8	13	Suggest that referrers to behaviour change programmes (e.g. primary care professionals who refer to existing programmes) are added to the 'Who should take action' section as they will often be the ones making an initial assessment.	Providers of behaviour change programmes and interventions would cover all healthcare professionals.
Slimming World	Recommendation 8	13	Could it be made clearer exactly who would be doing the assessment? People delivering a brief intervention wouldn't be able to do a full client assessment and so this wouldn't be relevant to them?	The recommendation highlights when only trained behaviour change practitioners should undertake the recommendations and links to training recommendations.
Slimming World	Recommendation 8	13	Suggest that the first bullet referring to the skills needed is moved to the training section in recommendation 15.	Thank you.

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Slimming World	Recommendation 8	13	How thorough would the assessment need to be? Would an assessment of someone's BMI be suitable as an assessment of need for behaviour change to help them lose weight? If yes, could this be made clearer i.e. explain that there would be different levels of assessment depending on individual circumstances.	Thank you for your comment. It was decided that this guidance would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in more detail. The level of detail you are requesting is not possible in this guidance. BMI would be a suitable assessment for determining need for weight change, but not for determining what someone needs to help them make changes.
Slimming World	Recommendation 8	13	The fourth bullet suggests that assessment of whether the person is capable of making the changes and an assessment of their environment is made – it is important to identify that this shouldn't just be a one off initial assessment, these things could change during the programme and should be continually assessed as part of the programme.	Thank you. The recommendation now has: 'Plan at what point before, during and after a behaviour change intervention a review will

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				be undertaken to assess progress towards goals and then tailor the intervention and follow-up support accordingly.'
Slimming World	Recommendation 9	14	Suggest that commissioners are removed from the 'who should take action' section and that health professionals be added in	Thank you for your comment. Healthcare professionals would be included under those providing behaviour-change programmes. The PDG felt commissioners should be included.
Slimming World	Recommendation 9	14	Suggest add a bullet in around referring health professionals ensuring that referrals to services are made at appropriate times (judging individual needs).	Thank you. We think this is covered in the recommendation.
Slimming World	Recommendation 10	15	Suggest the title for this recommendation changes to 'Delivery: Behaviour change techniques'	All recommendation titles have been changed.
Slimming World	Recommendation 10	15	We are unclear as to why researchers have been identified as a group who needs to take action in this recommendation.	Intervention designers have been identified as appropriate for this recommendation, this would include researchers, academics and practitioners. Specific mention of researchers has been removed from the recommendation.

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Slimming World	Recommendation 11	15	We suggest that recommendation 11 becomes part of recommendation 10. All behaviour change programmes should be based on principles that will be maintainable in the long term and should support people to cope with lapses. Having it as a separate recommendation implies that maintenance would be tackled separately yet it should be part of the overall programme for it to be sustainable.	Thank you for your suggestion, we do state in other recommendations that maintenance should always be considered.
Slimming World	Recommendation 11	16	Suggest the following wording 'people who make least change to everyday practices and routines are likely to be the most successful' is rephrased. This is confusing, could it be rephrased along the lines of 'people who make small changes gradually are likely to be the most successful'.	Thank you. The recommendation has been re-worded for clarity to 'small, manageable changes to daily routine are most likely to be maintained'.
Slimming World	Recommendation 13	17	Suggest a bullet point is added in along the lines of 'Ensure all health and social care professionals are trained and confident in raising the issue sensitively and on assessing readiness to change.	Thank you for your suggestion, however specific details concerning competences and characteristics are provided in later recommendations.
Slimming World	Recommendation 14	19	We question whether it would be the trainers job to assess participants (trainee's) motivation.	Thank you for your comment. Participant motivation would seem an important thing for any trainer to understand in order to provide appropriate, tailored training.
Slimming World	Recommendation 14	19	Suggest add confidence into the final bullet point in recommendation 14 e.g. …skills, knowledge and confidence when delivering interventions…'	Thank you for your suggestion. This change

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				has been made.
Slimming World	Recommendation 15	19	Suggest add in another point under 'ensure practitioners develop skills in' along the lines of 'a patient-led approach, with strong empathy and understanding' (so as not to be seen as judgemental by the patient).	Thank you. We have added 'Ensure practitioners are trained to adopt a person-centred approach when assessing people's needs and planning and developing an intervention for them'
Slimming World	Recommendation 17	21	Suggest that participant views should be collected in an evaluation and this should be added in to the recommendation.	Thank you for your comment. We have added that evaluation should include 'rigorous qualitative assessments to evaluate how well interventions will work in practice and how acceptable they are to services users and practitioners'
Slimming World	Recommendation 17	21	The recommendation suggests that independent evaluation should be carried out. Is this feasible and to what level would be expected? For example if a programme has been independently evaluated in a research trial and the results published, would every individual local programme also need to be evaluated to the same level or once one thorough evaluation of a programme has taken place, could a service level audit be carried out as a minimum from then onwards? It would be useful if this was clarified.	Thank you for your query. Information that should answer your queries is in recommendation 4.
Slimming World	Recommendation 18	22	It is suggested that the outcomes of behaviour change interventions should be monitored – how will this work if more than one intervention is going on at the same time?	We would expect each intervention to have its own data set.

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Sussex Community NHS Trust	General		I am a Health Promotion specialist working on cancer screening and early symptom recognition. It would be helpful if NICE Guidelines on Behaviour Change would reflect the work being done to bring about behaviour change in relation to cancer screening and early symptom recognition. The promotion of cancer screening and improving screening rates in low uptake areas requires skill in delivering a behaviour change programme to heath and allied professionals as well as patients and the public. Early symptom recognition also requires knowledge and understanding of the anatomy of the body as well as the ability to change attitudes, beliefs and feelings in relation to cancer treatments, cure, diagnosis, screening, episodes of cancer, and living well with cancer	Thank you for this background information. This guidance does not cover cancer screening or early symptom recognition. There is always a balancing act to be made when developing guidance to ensure that we can cover relevant evidence within the time and resources available for a piece of guidance.
Sustrans	General		Thank you for the opportunity to comment on this potentially very important guidance. Sustrans works on behaviour change in the fields of transport, planning, environment and public health, and a really important consideration for us is that the aspects of behaviour related to individual decision making are all too often seen as working in isolation. In reality of course, if the wider behavioural determinants point the wrong way – in our field, if they encourage sedentary motorised transport instead of active travel – then no amount of nudging will bring about sustained, significant behaviour change. Our first point therefore is that the guidance, and relevant NICE pathways and implementation materials, should repeatedly remind readers of the environmental determinants of behaviour – physical and cultural – so that they are not overlooked.	Thank you for this background information on your organisation. Environmental determinants of behaviour are out of scope for this guidance. We cannot repeatedly remind readers of all relevant information.
Sustrans	General		It is also worth noting that some highly effective behaviour change	Thank you for your

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			programmes may not be 'branded' health, and that Public Health will not be the only department in a local authority working to bring about behaviour change. In Sustrans' field, we and others implement programmes which bring about large-scale change from sedentary transport to active travel, with major impact on physical activity levels. Public health teams should be trained and supported to recognise these programmes as contributing to health objectives.	comment.
Sustrans	Section 1	P5	I will not subject you to the same point repeatedly throughout the draft, but Recommendation 1 is a good example of the first comment above: it would be wise for this recommendation to state, clearly, that the strategic approach should include objectives, measures, targets and monitoring addressing the physical and cultural environment relevant to the behaviours being addressed. It therefore follows that the strategy should consider not only public health commissioning (such as smoking cessation programmes) but also the wider influence of the public health team (for example working with other departments of the local authority to reduce speed limits to 20mph, or to implement cycle training).	Thank you for your comment. This guidance is on individual-level behaviour change interventions so these details would not be included in this piece of guidance.
Sustrans		P16 et seq	Recommendations 12 to 15 might indicate that training should cover the wider picture of environmental and social determinants of behaviour.	Thank you for your comment but this is out of scope for this piece of guidance.
Sustrans	Section 5	P35	Here, or elsewhere, it may be useful to include a reminder that NICE recommends not only 'health-branded' behaviour change interventions. For example, PH41 considers Personalised Travel Planning (PTP): public health professionals might not automatically think of such an approach when	Thank you for your comment but we are not sure what you mean by 'health-branded' interventions. Any

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			considering possible behaviour change commissions, but PTP has been shown to be cost-effective as a health promoting intervention, aside from its impacts on congestion, accessibility etc.	intervention that is not an individual-level intervention would not be referred to in this guidance.
Terrence Higgins Trust	General		Terrence Higgins Trust is the UK's largest HIV and sexual health charity, with 31 service centres across the UK. We are a campaigning and membership organisation which advocates on behalf of people living with or affected by HIV or poor sexual health. We provide services for people living with HIV to manage their condition and access emotional and practical support. These include one-to-one counselling, peer support groups, health trainers and information and advice covering benefits, housing, finances, employment and immigration. We also deliver community based clinical services, such as chlamydia screening and rapid HIV testing, and health promotion campaigns and initiatives which target populations most at risk of HIV and poor sexual health.	Thank you for this background information on your organisation.
Terrence Higgins Trust	General		We welcome the opportunity to comment on the draft guidelines for Behaviour Change. Overall, we believe that as the guidance covers a wide range of behaviours it does not always consider the specific behaviours and the complexities associated with them. The recommendations risk placing behaviours in isolation from wider structural barriers, cultural and societal factors that complicate behaviour change.	Thank you for your comment. It was decided that this guidance would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in

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				more detail. Please note that several recommendations address your latter concern, for example in recommendation 1: 'Strategies and policy should aim to improve everyone's health. Ensure the content, scale and intensity of each intervention is proportionate to the level of social, economic or environmental disadvantage someone faces and the support they need.'
Terrence Higgins Trust	Introduction	1	Whilst the guideline is for behaviour change techniques for individual level interventions and choice architecture, the complete lack of recommendations for choice architecture interventions means that the guideline cannot possibly claim to cover these interventions. Whilst there are research recommendations this is not sufficient to claim that the guidelines address choice architecture.	Thank you for your comment. Please note that in the draft guidance we did state at the beginning that while it was our intention to cover choice architecture interventions – this is what was expected on the basis of what we said we would be looking at in

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				the Scope for this guidance - we were not able to make recommendations on choice architecture interventions due to lack of supportive evidence: 'The scope for this guidance set out to address: behaviour-change techniques for individual-level interventions 'choice architecture' interventions. … No recommendations concerning choice architecture interventions were made (see considerations and recommendations for research).' This information is now in the 'about this guidance' section.
Terrence Higgins Trust	General		The role that commissioners play in facilitating, or otherwise, is not adequately addressed. Whilst identifying who should take action within each recommendation is helpful it does not sufficiently address the structural barriers that can sometimes occur and the role that commissioners themselves play in making appropriate decisions.	Thank you for your comment. We do not recommend 'that finance should be invested proportionately to the

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			This is in part addressed by the training recommendations in recommendation 7 but further undermined by the emphasis placed on acceptability (p.9), improving everyone's health and proportionate intervention (p.5). This could ultimately place pressures on commissioners and risk forcing them to deprioritise addressing difficult and challenging behaviours in small subgroups. By stating that finance should be invested proportionately to the problem real issues could be ignored simply because it would cost too much money for the population size. This could result in cutting and decommissioning.	problem', we are recommending 'the content, scale and intensity of each intervention is proportionate to the level of social, economic or environmental disadvantage someone faces and the support they need.' It is out of scope for us to be making recommendations in the detail you are suggesting about the behaviours of commissioners, and would require the PDG to look at evidence specifically relating to commissioning practices.
Terrence Higgins Trust	Recommendation 2	6	NICE recommendations are respected and of a high standard. To commission interventions that meet NICE recommendations and are proven to be effective over the long term would risk stifling innovation and dissuading commissioners of utilising interventions simply because they do not meet the required standards. This is serious as the standards, as they are set so high, risk excluding interventions because they have not undergone randomised controlled trials. RCTs will not always be an option, particularly where an intervention aims to provide an appropriate intervention and support based on an individual's	Thank you for your comment. In recommendation 16 we reference the Medical Research Council guidance on the development, evaluation and implementation of complex interventions to

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			needs and choice or where the target population is small and numbers are not sufficient for a RCT. The recommendation on quality and effectiveness(p.8) acknowledges that some programmes will be commissioned without evidence and we support that these should be comprehensively evaluated. The guidelines would benefit from further discussion around piloting and testing as very little guidance is given.	improve health, which provides details on piloting and testing. This guidance is not meant as a comprehensive guide to intervention development.
Terrence Higgins Trust	Recommendation 3	7-8	The guidelines do not clearly differentiate between interventions being efficacious and effective. Randomised control trials will measure how efficacious an intervention is within an ideal and controlled environment but they are unable to measure how effective an intervention will be within a 'real' setting. This may, in part, be dependent on the fidelity to the programme which would be measured through on going programme evaluation but not entirely. Even if a programme or intervention is followed perfectly with complete fidelity the 'real world' setting may have additional environmental or societal factors that prevent it from being as efficacious as in the RCT. This needs to be addressed within the guidelines.	Please note that this guidance is not intended as a guide on how to undertake research.
Terrence Higgins Trust	General		The mixture between individual and group/community interventions and the guidance for each is blurred where there should be distinction. Specific recommendations (for example, recommendation 9)should consider whether they are relevant for individual interventions and/or group/community/population interventions. The guidelines in their current form often assume that behaviour change architecture is on an individual level which is not always the case. In each case a differentiation between the guidance relevant for individual or group/community/population interventions should be made.	This guidance is on individual level interventions only as no recommendations on choice architecture interventions were made.
Terrence Higgins Trust	Recommendation 6 and 8	13	Recommendation 6 and 8 provide a good example of where the guidelines do not easily apply for sexual health interventions, and possibly others.	Thank you for your comment. It was decided that this guidance

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			Discussions about where a behaviour exists and where 'the person needs to change their behaviour' do not acknowledge that for sexual health it is not only one person's behaviour but two, if not more. Sexual health, by its very nature, is relational and interactive between individuals. The wider environmental, social, economic and cultural influences need to be considered and the guidelines risk overly simplifying the complicated interaction between individuals and their surroundings. In addition, for sexual health there is the added complication of power and relationships and the assumption that individuals will have control over their behaviour which is not always the case. Consideration of financial exchange and gender inequalities need to be given to ensure that sexual health interventions are context specific. Gender, sexuality, ethnicity and socioeconomic status should be the basis for basic contextual considerations, with additional factors where appropriate. Any behaviour change intervention needs to be appropriately provided in a setting that is considerate of their community and any stigma that could be attached to the behaviour. This is particularly important when trying to engage with hard to reach populations or where an individual's behaviour might not be accepted within a particular community.	would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE guidance which is able to cover evidence on interventions for a particular behaviour in more detail. Concerns about this guidance not being relevant to sexual health were discussed by the PDG and they decided that the recommendations are relevant to sexual health. Please note several PDG members work within sexual health.
Terrence Higgins Trust	Delivery 3.27	30	The concern regarding how people access interventions and the risk that they might widen health inequality falsely assumes that primary care is the sole route currently used. For many years third sector providers such as Terrence Higgins Trust have provided community setting interventions targeted at relevant populations and individuals within it. The PDG would benefit from considering what is already happening.	Thank you for your comment, but the consideration specifically states that not everyone accesses primary care services.
Terrence Higgins Trust	4. Recommendations for Research -	34-35	The issue of efficacy and effectiveness is once again raised in the research recommendations. We would refer the PDG to Professor Susan Kippax's paper "Reasserting the social in a biomedical epidemic: The case of HIV prevention", 2010.	We are unable to accept or review additional evidence at this stage. The focus is on effectiveness as this indicates how beneficial a test or

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				treatment is under usual or everyday conditions, compared with doing nothing or opting for another type of care. As efficacy is about how beneficial a test, treatment or public health intervention is under ideal conditions (for example, in a laboratory), compared with doing nothing or opting for another type of care, we would not be emphasising assessing efficacy.
Terrence Higgins Trust	4.3		The focus on psychological theories of behaviour change alone does not consider the wider societal and structural barriers and challenges that need to be considered in public health. This means that there is a focus on randomised controlled trials. The recommendations need to call for longitudinal studies, qualitative research to understand the acceptability of interventions within communities and how individuals access interventions.	The recommendations state qualitative research should be undertaken. Nowhere do the recommendations state that only RCTs should be undertaken. Please note that this guidance is not intended as a guide on how to undertake research.
Terrence Higgins Trust	General		Overall, there is a lack of focus on the context and societal factors that will affect the effectiveness of an intervention. The guidance is heavily weighted towards the organisational structure, process, training, and planning rather than what will ensure the commissioning of high quality, efficacious and effective interventions.	Thank you for your comment. However, we do not agree with your view that the recommendations do not cover context and

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				societal factors – these are addressed in relation to individuals' needs. It is out of scope for this guidance to address community or population level interventions and we are not currently able to provide recommendations concerning choice architecture interventions (see response above). We think this guidance makes clear recommendations concerning quality and effectiveness.
The British Psychological Society	General		The Society welcomes this update to Public Health Guidance – Behaviour Change (partial update of PH6). The recommendations are comprehensive and clear and appropriate to the different stages from policy development to assessment and feedback.	Thank you.
The British Psychological Society	General		The Society notes that the guidance makes no mention of targets for change in the recommendations which is appropriate as they are referred to in the specific behaviour guidance linked to this guidance. However, targets are controversial and often not appropriate for all people. The society recommend that the background should include the comment: *"This document does not comment on specific targets for behaviour change. For advice on these you should refer to the behaviour specific NICE*	Thank you for your comment but we are not able to mention all the things that the guidance does not cover.

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			guidance."	
The British Psychological Society	General		The Society welcomes the use of evidence-based broad principles in 'what works' (goal setting, feedback, social support) , rather than a very prescriptive recommendation, since they allow localities to be able to work within the broad principles to devise programmes that 'fit' local culture and skills.	Thank you.
The British Psychological Society	Recommendation 1		The Society suggests that see health literacy should be included in recommendation 1. From an inclusion point of view we need to give due consideration to the levels of ability to access and engage with interventions. Improving Health Literacy is an evidence-based way of increasing inclusivity. We would recommend the additional action point. *Ensure strategies reflect levels of health literacy in their target populations*. **Supporting evidence:** Nutbeam, D (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, Oxford University press*, **15(3)**, 259	Thank you for your suggestion. The ethos of the recommendation is that policy addresses individual's needs, this would include issues such as health literacy which should also be addressed in planning and delivery of interventions.
The British Psychological Society	Recommendation 1	5	Development of a strategy should not be undertaken in isolation of existing health and social care services that may already be providing behaviour change interventions and services. It is essential that the local strategy links in with such services supports such services and ideally provides a comprehensive system that facilitates integration of behaviour change strategies/services as it is rare that health-impacting behaviours occur in isolation.	Thank you. We do not think any changes need to be made to the recommendation as commissioners should be aware of through needs assessment process, etc of which other services are available. Please note that this is not meant as comprehensive guidance on how to develop

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				policy.
The British Psychological Society	Recommendation 2	7	The Society considers that commissioning of behavioural change interventions/programmes should include ongoing supervision and support for staff from appropriately trained practitioners to ensure the continued delivery of effective behaviour-change interventions.	Thank you for your comment. These issues are addressed in recommendations 2 and 11. Please note that all the recommendations in the guidance should be looked at together rather than in isolation; and Recommendations are written in a way to avoid repeating information in other recommendations where possible.
The British Psychological Society	Recommendation 2	6	Some attempts to commission behaviour change services in the past have been unsuccessful and lessons need to be learned. This is something that should be acknowledged in the guidance. It should also be more explicit in directing commissioners to avoid such pitfalls and for them to be aware of the complex nature of behaviour change/interventions which requires high level knowledge and skills. Services should be organised to meet the needs of the patients/users and not vice versa; as such, 'revolving door' access should be facilitated as relapse is part of a behaviour change process and not a failing on the part of the person attempting to make the change(s).	Thank you for your comment. The committee did not review evidence concerning behaviour change service lessons and so are not able to make recommendations concerning where things have previously gone wrong. The recommendation states that strategies should address relapse and recognise that this is

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				common. In recommendation 1 it is made clear services should be about meeting individual's needs.
The British Psychological Society	Recommendation 2	7	Information governance, confidentiality and consent requirements should be included wherever changes to information systems or further collection of data are suggested.	Thank you for your comment. All organisations should be aware of legal requirements and ensure they are met.
The British Psychological Society	Recommendation 3	7	The Society suggests that the actions for recommendation 3 include: *Ensure that staff continues to receive ongoing support and supervision from appropriately trained practitioners to ensure that behaviour change interventions continue to be delivered as planned and are of good quality.* This is in line with the best practice requirements for practitioners of the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC).	Thank you for your comment – this is covered in recommendation 2.
The British Psychological Society	Recommendation 3	7	The Society welcomes the recommendation to investigate whether existing behaviour-change interventions and programmes are effective and applying evidence –based principles.	Thank you for your comment.
The British Psychological Society	Recommendation 3	8	The Society supports the recommendation to only commission interventions for which there is no evidence of effectiveness when they are accompanied by an adequately powered and controlled evaluation that measures relevant out comes but would like to add the comment to action point 5: *"Only commission an intervention for which there is no evidence of effectiveness if it is accompanied by an adequately powered and controlled evaluation that measures relevant outcomes."*	Thank you for your comment, but this seems to be the same as the original recommendation wording?

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The British Psychological Society	Recommendation 3	8	The Society supports the recommendation to disinvest if there is good evidence to suggest programmes that are not effective. Although it may be helpful to attempt to clarify what they mean by "good evidence" in this context.	Thank you for your comment. Please note that this guidance is not intended as a guide on how to undertake or interpret research.
The British Psychological Society	Recommendation 4	8	The Society supports the inclusion of behavioural change knowledge and skills in job descriptions but recommends that the reviewing should be carried out by practitioner psychologists if available. We would suggest amending action 2: *"Managers should review job descriptions **(via practitioner psychologists where possible)** to ensure they include behaviour-change knowledge and skills (competencies), if they are relevant to a person's job (see recommendation 7). "*	Thank you for your comment but we have not seen evidence to suggest this is the case.
The British Psychological Society	Recommendation 4	9	The Society believes that staff delivering behaviour-change interventions should receive regular, ongoing supervision and support from appropriately trained practitioners to enable staff to consolidate and develop skills. This will help staff to develop confidence in working with clients with more complex difficulties and ensure that behaviour change interventions continue to be of good quality. We therefore suggest that the 5th action point amended as follows: *"Directors and managers should encourage staff to receive behavioural-change training related to their roles and responsibilities (see recommendation 7) They should also be offered ongoing professional development on behaviour-change theories and methods. **They should also receive ongoing supervision/support for their practice from appropriately trained practitioners.**"*	Thank you. The recommendation has been amended to incorporate this.
The British Psychological	Recommendatio	9	The Society welcomes the focus on on-going training and support but feels	Thank you. Please se

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Society	n 4		such support must come from appropriately trained practitioners. Hence we recommended the following amendment to the 6th action point. *"**Appropriately trained** managers, mentors and supervisors should support staff who are delivering behaviour change interventions*. "	response above.
The British Psychological Society	Recommendation 5	10	The Society suggests the following amendments under the action point 4: "Take into account": *- Follow up and support to maintain the new behaviour **that takes into account the time frames articulated in recommendation 2.*** *- Plans to monitor and measure intervention fidelity **that include an appropriate measurement gap for behaviour change to occur**.* **Supporting literature e.g.,** McEachan, R.R.C., Conner, M., Taylor, N. & Lawton, R.J. (2011) Prospective prediction of health-related behaviors with the Theory of Planned Behavior: A meta-analysis*. Health Psychology Review,* **5(1)**, 97-144 Sheeran, P. & Orbell, S. (1998) Do intentions predict condom use? Meta-analysis and examination of six moderator variables*. British Journal of Social Psychology,* **37(2)**, 231-250	Thank you for your suggestions. We do not think it is necessary to link to recommendation 2 [now rec 3] here – links to other recommendations are only made when completely necessary. A balance needs to be made so that the recommendations do not become unwieldy. All recommendations in the guidance should be taken as a whole. The recommendation concerns broad principles; issues around evaluation are detailed elsewhere. Please note that we cannot look at additional evidence at this stage.
The British Psychological	Recommendatio	10	The Society suggests the inclusion of an additional point under action 4 to	Thank you for your

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Society	n 5		address the unique situation in sexual behaviour where "risky" behaviour involves a sexual partner - ***For sexual behaviour the role of the sexual partner in the opportunity to not perform risky behaviours.*** **Supporting literature e.g.,** Bennett, P. & Bozionelos, G. (2000) The Theory of Planned Behaviour as predictor of condom use: A narrative review*. Psychology, Health & Medicin*e, **5 (3)**, 307-326 Broccoli, T. L. & Sanchez, D.T. (2009) Implicit hopelessness and condom use frequency: Exploring non-conscious predictors of sexual risk behaviour. *Journal of Applied Social Psychology* **39(2)**, 430-448	suggestions, The PDG made the decision not to make recommendations that specifically address one of the behavioural areas covered as there is existing guidance for this. Please note that we cannot look at additional evidence at this stage.
The British Psychological Society	Recommendation 6	11	The Society welcomes the inclusion of clearer intervention protocols in journal publications in order that interventions may be systematically reviewed and assessed. However, there may be copyright and quality control and safety implications if very detailed protocols or step by step manuals of behaviour change interventions written for health professionals delivering the intervention are widely available on a public unregulated website. Therefore systems need to be in place for the intervention manuals to ensure their proper use by appropriately trained individuals. Consequently, the Society recommends that action point 4 is amended: *"**Whenever possible (subject to copyright limitations and training prior to use requirements)** make the manual publicly available for example on a website."*	Thank you for your comment. The recommendation has been amended to highlight the need to provide copyright details and 'training before use' requirements in manuals.
The British Psychological Society	Recommendation 6	11	Manualised interventions may not be effective for all people requiring support with behaviour change, it would be helpful if the guidance gave scope for providing care and input for those of which more standardised approaches have not worked.	Thank you for your comment. There is no reason why manuals could not provide details about approaches that vary depending on

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				clients' needs; bullet 3 sub-bullet 4 specifies 'tailoring to individual needs'. We would advocate this sort of information in a manual – please see recommendation 8.
The British Psychological Society	Recommendation 7	12	The Society believes that ongoing support, from appropriately trained practitioners, should be available to staff who have been trained in delivering very brief, brief or high intensity interventions, to support these staff in the continued use of these behavioural-change interventions. Consequently, we suggest the inclusion of an additional action point: *"All staff delivering behavioural change interventions should have access to ongoing support from appropriately trained practitioners."*	Thank you for your comment. This is recommended in recommendation 2 on organisational support and recommendation 11 on commissioning in training. This recommendation is about delivery.
The British Psychological Society	Recommendation 8	13	Self-efficacy has been demonstrated to be a key factor in successful behavioural change and consequently recommend an additional point under action point 4 : *In depth assessments should determine what help the person needs to change their behaviour. This includes:* - how confident the person is about change **Supporting evidence:** Williams et al (2007) Do brief measures of readiness to change predict alcohol consumption and consequences in primary care patients with unhealthy alcohol use? Alcoholism: Clinical and Experimental Research, **31**, 428-435.	Thank you for your comments. We think this is covered in the recommendation (in particular capability is addressed – please see glossary). Please note that we are unable to accept or review additional evidence at this stage.

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The British Psychological Society	Recommendation 8	13	The Society notes that while Principle 4 in PH Guidance 6 (2007) is referred to in the new draft guidance, the spirit of this principle is not visible in the draft document. The title 'client assessment' suggests a classic medical model for approaching the issue of addressing 'needs assessment' issues. The Society would suggest renaming this recommendation: ***Delivery: needs assessment and user involvement***	Thank you. The title has been changed.
The British Psychological Society	Recommendation 8	13	Behaviour change does not just involve capability, context and motivation; it has a significant impact upon by a person's cognitive function, attitudes, expectations, beliefs and health representations. This needs to be acknowledged and allowed for within the guidelines for assessment.	Thank you for your comment. The PDG reviewed evidence for this model (see expert paper 3). We are not stating that other factors are not important in explaining behaviour. For the purposes of an individual-level intervention we are highlighting the need to assess and address capability, opportunity and motivation.
The British Psychological Society	Recommendation 9 and 11 (also links to section 3.37)	14 and 16 (32)	When supporting behaviour change, there is a need to encourage supporting individuals to get back on track if they relapse and not hamper an individual's change. The Society would recommend an additional bulletin point: "*Provide positive non-judgemental support for individuals if they are unable to adhere to their planned change in behaviour*." **Supporting literature e.g.,** Hancock, J., Lees, S. & Brown, K.E. (2011) Health psychology's role in sexual health care*. Europe's Journal of Psychology* **7(3)**, 550-564	Thank you for your comment. This would be part of feedback and monitoring. Further details concerning techniques are referenced in the glossary.

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			Harding, R., Dockrell, M.J.D., Dockrell, J. & Corrigan, N. (2001) Motivational interviewing for HIV risk reduction among gay men in commercial & public sex settings. *AIDS Care* **13(4)**, 493-501 Michie, S., Rumsey, N., Fussell, A., Hardeman, W., Johnston, M., Newman, S. & Yardley, L. (2008) *Improving Health: Changing Behaviour - NHS Health Trainers Handbook*. London: Department of Health Norman, P., Abraham, C. & Conner, M. (2000) *Understanding and Changing Health Behaviour: From Health Beliefs to Self-Regulation*. Amsterdam: Harwood Academic Publishers Rollnick, S. & Miller, W.R. (1995) What is Motivational Interviewing? *Behavioural and Cognitive Psychotherapy,* **23**, 325-334	
The British Psychological Society	Recommendation 9	14	The Society (and the guidance itself in recommendation 1) recognises that there are frequently several needs, and they may be conflicting. Consequently, we would suggest changing the title of recommendation 9 to: *"Delivery: Meeting individual needs."*	Thank you. This has been changed in the title.
The British Psychological Society	Recommendation 9	14	The Society notes that action point 1 refers to addressing the needs of people with disabilities. The Society thinks that this should be expanded to make it clear that this includes people with learning disability and possibly include other groups: disadvantaged groups, people with Severe Mental Illness (SMI). We suggest the amendment: *"Tailor interventions to meet different participant's needs (that is tailor them to their capability, opportunities and motivation to change). This includes addressing the specific needs of people with any type of disability* ***(including learning disabilities and mental health problems)****"*	Thank you for your comment. Highlighting a particular disability/disabilities seems questionable as this is about tailoring to all needs.
The British Psychological Society	Recommendation 9	14	The Society suggests that wording of action point 3 could be amended to read more positively: *"Recognise the* ***opportunities*** *when people may be more open to change....."*	Thank you for your suggestion. We do not feel this change is necessary as it does not change the meaning of the recommendation.

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				All NICE guidance goes through an editing process to ensure guidance is written in as plain English as possible to ensure it is clear to a wide audience.
The British Psychological Society	Recommendation 9	14	The Society believes that discussion of the likely impact of the intervention should go beyond health outcomes. That is, intrapersonal and social well-being outcomes should also be discussed as these are likely to be important too. Consequently , we would recommend amending the 4th action point: *"Discuss what the likely impact on their health and **wider well-being** will be if they do make changes."*	Thank you. Your suggestion has been incorporated into the recommendation.
The British Psychological Society	Recommendation 9	14	The Society believes that the use of the words "their" and "they" in action point 4 is unclear and would recommend the following amendment: *"Discuss what the likely impact on **the participant's** health will be if they make changes."*	Thank you. Your suggestion has been incorporated into the recommendation.
The British Psychological Society	Recommendation 10	15	The Society believes that the term relapse is not appropriate to all behavioural contexts. In action point 1, Under 'goals and planning', point 3. The words '*prevent relapse'* should be replaced with either '*prevent lapse'* or better still, '*overcome barriers to maintenance of change'.*	Thank you for your suggestion but we do not agree. All NICE guidance goes through an editing process to ensure guidance is written in as plain English as possible.
The British Psychological Society	Recommendation 10	15	The Society recognises that there are motivational challenges 'ahead' of goal setting and planning. This pre-contemplation stage of change, as it has been called in the trans-theoretical theory of change, should be acknowledged and appropriate techniques provided. We propose the following amendment to action point 1. Before Goals and Planning:	Thank you for your comment. We are not recommending the trans-theoretical model of change. Please see

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			Awareness raising (through education or other methods) **Supporting evidence:** Prochesta & DiClemente (1983). Stages and processes of self-Change smoking: towards an integrative model of change. Journal of Consulting and Clinical Psychology, **51**, 390-395.	consideration 4.48.
The British Psychological Society	Recommendation 10	15	The Society believes that the final sentence of the second bullet point "*Provide a rationale for their inclusion in the intervention"* is not clear. If it is highlighting the importance of engaging clients in interventions by explaining the rationale behind the different techniques, this isn't made clear in the document. The Society would suggest the following amendment: *"Do not necessarily limit an intervention to these behaviour-change techniques. Make sure all of them are clearly defined. Explain* ***to participants*** *the specific reasons that they have been identified as benefitting from this intervention."*	Thank you for your comment. This does not refer to explaining to participants, it is to ensure researchers/intervention designers make clear why techniques have been used. The recommendation is about what providers of behaviour change interventions and programmes and intervention designers should do.
The British Psychological Society	Recommendation 10	15	2nd bullet point, action – 2nd sentence should be better worded. The Society would suggest the following amendment: "*Make sure all behaviour-change techniques are clearly defined*."	Thank you. Your suggestion has been reflected in the re-drafting of the recommendation.
The British Psychological Society	Recommendation 11	16	The Society welcomes emphasis on maintenance of behaviour and the use of action plans. Action plans should be co-produced with each participant.	Thank you for your comment. The guidance highlights the importance of taking a person-centred approach. The introduction to this guidance

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				now states that 'The recommendations should be implemented together, using a person-centred approach'
The British Psychological Society	Recommendation 12	17	The Society would suggest the following amendment to action point 2, by adding an additional component that training programmes on behaviour change provide: *"Ensure staff have access to ongoing supervision / support from appropriately trained practitioners, to facilitate staff's consolidation and development of skills in behaviour change interventions."*	Thank you for your comment. This is covered in recommendation 2.
The British Psychological Society	Recommendation 13	17	The Society suggests the following amendment to action point 1. *"Integrate behaviour-change knowledge, skills and delivery techniques as a formal element in initial training, work placements and ongoing continuous professional development for all those who deliver health and social care services.* ***Ensure that that staff have access to ongoing support for this aspect of their work'.****"*	Thank you for your suggestion, however we think the additional sentence is redundant as we already state 'on-going CPD', and support is also address in recommendation 2.
The British Psychological Society	Recommendation 14	18	It is not clear whether 'support services' refer to behaviour-change interventions or services which support maintenance. This appears to have been used to refer to different things in the 4th point and the 5th point.	Thank you for your comment. Your suggestion has been reflected in the re-drafting of the recommendation.
The British Psychological Society	Recommendation 15	19	The Society notes that Motivational Interviewing Research indicates that clear and defined approaches should be used to enhance motivation, e.g., selectively reinforcing change talk. We suggest the following amendment to action point 3(5): *- Developing motivation through reflective listening, empathy and* ***reinforcing change talk.*** **Supporting evidence:**	Thank you for your comments. The skills in this recommendation are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked document

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			Rollnick & Miller (1995) What is Motivational Interviewing? Behavioural and Cognitive Psychotherapy, **23**, 325-334.	(previously in **section 9** of the draft guidance) which links recommendations to the evidence.
The British Psychological Society	Recommendation 16	20	The Society believes that under the point 'who should take action'; clients should also be given the opportunity to feedback. It is the view of service users that often enhance services. Feedback can be brief and anonymous (e.g., questionnaire), or more open and detailed (e.g., interview with service users). We recommend including ***Participants*** in the list of who should take action. **Supporting literature e.g.,** Albarracín, D., Leeper, J., Earl, A. & Durantini, M.R. (2008) From brochure to videos to counselling: Exposure to HIV-prevention programs. *AIDS & Behavior* **12(3)**, 354-362 Kalichman, S.C., Cain, D., Knecht, J. & Hill, J. (2008) HIV/AIDS information needs of sexually transmitted infection clinic patients: Content analysis of questions asked during prevention counselling. *Sex Education,* **8(1)**, 11-23	Thank you for your comment. We do not make recommendations to participants as a group under 'who should take action' but the recommendation has been amended to highlight the importance of service user feedback.
The British Psychological Society	Recommendation 16	20	A facility for practitioners to develop reflective practice skills should be included here, so that supervision can enhance practitioner development and efficacy, rather than just monitor and give feedback on competence.	Thank you for your suggestion but this recommendation is about assessment and feedback. We have not reviewed any evidence on reflective practice facilities.
The British Psychological Society	Recommendation 17	22	The Society notes that this recommendation does not recognise that qualitative research is an important and valuable tool in the evaluation of complex interventions. The wording of this recommendation about measures, especially about avoiding self-report, seems to preclude the use of any qualitative data though point 3.40 on page 33 explicitly states that the PDG	Thank you for your comment. We have added that evaluation should include 'rigorous qualitative assessments to evaluate how well interventions

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			notes that qualitative measures are important. The Society proposes the additional action point: *"Include rigorous qualitative assessments of interventions where appropriate."*	will work in practice and how acceptable they are to services users and practitioners'
The British Psychological Society	Glossary	36	The Society notes that brief interventions can also be delivered by computer assisted technologies. We propose adding a final sentence to paragraph 3, page 36: ***Brief interventions can be delivered by computer assisted technologies.*** **Supporting literature e.g.,** Fogg, B.J. (2003) *Persuasive Technology: Using computers to change what we think and do.* San Francisco: Morgan Kaufmann Publishers Hancock, J. (2013) Exploration of five condom-related behaviours in the UK: Development and evaluation of an online safer sex intervention. (Unpublished doctoral thesis). Coventry University Noar, S.M., Black, H.G. & Pierce, L.B. (2009) Efficacy of computer technology-based HIV prevention interventions: A Meta-Analysis*. AIDS,* **23(1)**, 107-115 Webb, T.L., Joseph, J., Yardley, L. & Michie, S. (2010) Using the Internet to promote health behavior change: A systematic review and meta-analysis of the impact of theoretical basis, use of behavior change techniques, and mode of delivery on efficacy*. Journal of Medical Internet Research* **12(1)**, e4	Thank you but we try to limit a glossary to information that is necessary for someone to understand a term.
The Health Foundation	**General**		**About the Health Foundation and our response** The Health Foundation is an independent charity working to improve the quality of healthcare in the UK. We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work. We are here to inspire and create space for people to make lasting improvements to health services. We conduct research and evaluation, put	Thank you for this background information on your organisation.

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			ideas into practice through a range of improvement programmes, support and develop leaders and share evidence to drive wider change. The Health Foundation welcomes the opportunity to comment on the NICE draft guidance on behaviour change (partial update of PH6). Guidance that helps commissioners, service providers, health and social care professionals and others to take an evidence based approach to supporting people to change behaviours that are or may be harmful to their health is important. Our response focuses on the areas where we can offer the most constructive input, based on what we have learnt as a result of our research and our improvement and leadership programmes.	
The Health Foundation	**General**		As currently drafted we believe the guidance misses an important opportunity to ensure that the commissioning and delivery of behaviour change interventions is effective in supporting people living with long-term conditions or ill-health to more effectively manage their health and care, including through living more healthily. This is important as in England more than 15 million people – almost one in three - have at least one long-term condition. About 70 percent of the primary and acute care budget in England goes toward treatment and care for people with long-term conditions.[6] The Department of Health expects the number of people with one long-term condition to remain	Thank you for your comment. All NICE guidance goes through an Equity Impact Assessment (EIA) to ensure no groups are excluded and to see where changes can be made to ensure

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			stable for the next ten years, but the number of people with multiple conditions to rise by a third.[7]	everything possible is done to include people with any disabilities or other protected characteristics. The guidance has undergone a re-draft in light of this EIA, so we hope these address your concerns.
The Health Foundation			[1]http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm [2] www.gov.uk/government/policies/improving-quality-of-life-for-people-with-long-term-conditions	Please note that we are unable to accept or review additional evidence at this stage.
The Health Foundation	**General**		There are four key areas where we believe changes to the guidance are needed to ensure that it is effective: • **Scope** - Make explicit that the guidance covers behaviour change techniques for people living with long-term conditions (secondary prevention) - Incorporate the evidence that supporting people to more	Thank you for your comments. Please note that no changes can now be made to the scope as these set out what we would be doing with this guidance and have already been subject to stakeholder consultation.

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			effectively self manage underpins behaviour change • **Changes to language and tone** - Ensure the language and tone is consistent with that used in health service delivery • **Reframing the guidance to emphasise person-centred care** - Support to improve a person's knowledge, skills and confidence should be the starting point for behaviour change - Recognising the importance of collaborative agenda setting alongside goal setting and follow-up to support changes in behaviour for people with long-term conditions	Please note that the health service, while one of our main audiences, is not the only audience for whom this guidance applies, as such we try to ensure that the language is accessible to as many people as possible. The guidance highlights the importance of taking a person-centred approach. The introduction to this guidance now states that 'The recommendations should be implemented together, using a person-centred approach'; and please see recommendation 8. Training and support are highlighted in recommendations 2, 11-

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			• **Support for health and social care professionals** - Recognise that supporting people to self manage requires a change in mindset and professionals need training *and* support in order to do this - Include agenda setting as an essential skill professionals need to develop - Clarify the typology of interventions and minimum skills sets We also believe that greater clarity about how the guidance is to be implemented and recognition of some of the challenges in this area would be helpful. We have expanded on these points below.	14. The skills highlighted in the recommendations are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked document (previously in **section 9** of the draft guidance) which links recommendations to the evidence. Interventions are defined in the glossary. All skills identified should be addressed. The guidance does not address how it will be implemented, there are Implementation tools that accompany the guidance.
The Health Foundation	**4.3-4.5**	**35**	We welcome and support the recommendations made by the Programme Development Group (PDG) for further research. Our own review of the evidence on self management support has identified the need for further research to understand: the best strategies for motivation people to change their behaviours; how applicable current research is to people with long-term conditions; and the best strategies to help clinicians support self-management	Thank you for your comment. We are unable to accept or review additional evidence at this stage.

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			and behaviour change.[8]	
The Health Foundation			[3] De Silva, D. *Helping people help themselves, a review of the evidence considering whether it is worthwhile to support self-management*, London: The Health Foundation; May 2011, p.18-19.	We are unable to accept or review additional evidence at this stage.
The Health Foundation	**General**		***Scope of the guidance*** The current draft guidance sets out to be broad in scope and apply to behaviour-change techniques for individual-level interventions in relation to alcohol, diet, physical activity, sexual behaviour and smoking. But the principle focus of the draft is on a range of behaviour change techniques and interventions aimed at preventing ill health (primary prevention). We believe that this is too narrow. The opportunities to engage with people with long-term conditions around issues such as smoking, drinking, diet or physical activity are most likely to arise in consultations with doctors, nurses and other health professionals as part of the ongoing treatment and management of their long-term condition (or conditions). We believe that not explicitly including behaviour change for this large group of patients in the guidance risks undermining its effectiveness in supporting behaviour change in the areas identified. Broadening the scope of the guidance to explicitly cover behaviour-change interventions for people living with long-term conditions (secondary	Please see response above.

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			prevention) would also allow the PDG to take into account the evidence base about what works to support people with long-term conditions to more effectively self-manage.[9,10,11,12]	
The Health Foundation			[4] De Silva, D. *Helping people help themselves, a review of the evidence considering whether it is worthwhile to support self-management*, London: The Health Foundation; May 2011. (http://www.health.org.uk/publications/evidence-helping-people-help-themselves/) [5] *Co-creating Health: Evaluation of first phase*, London: The Health Foundation; April 2012 [6] Co-creating Health: Evaluation of second phase to be published early autumn 2013. [7] *Invest in Engagement*- a review of 124 systematic reviews on self-management support, Picker Institute Europe, 2010. (http://www.investinengagement.info/45)	We are unable to accept or review additional evidence at this stage.
The Health Foundation	**General**		***Language and tone*** Many of the ultimate users of the guidance will be frontline NHS staff and those commissioning health services for patients with long-term conditions. It is important that the interventions to support behaviour change are considered in this wider context and that the guidance for commissioners and health and social care professionals is consistent in its language, approach and	Please see responses above.

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			messages with that used in health service delivery. We believe that the guidance as currently drafted does not do this. Much of the language of the guidance is still weighted towards the person providing the care being in control. For instance, the guidance talks of professionals assessing a person's behaviour to 'determine what help the person needs to change' including their 'capability, opportunities and motivations to change'. We would argue that it is the professional's role to support patients to understand their own motivations to change and to have the confidence, knowledge and skills to change their behaviour. As currently described, the focus is on behaviour change interventions that health and social care professionals are trained to 'deliver' rather than something that is part of a collaborative process with the patient at the centre. We recommend that this guidance is aligned with NICE CG138 *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services*. This guidance recommends an individualised approach to healthcare services that is tailored to the patient's needs and circumstances, taking into account their ability to access services, their personal preferences and coexisting conditions. It advocates that discussions with patients should encourage them to express their personal needs and preferences for care, treatment, management and self management support.	
The Health Foundation	**General**		***A person-centred approach*** We believe that self-management support is key to supporting behaviour change for people with long-term conditions and this needs to be	Please see response above concerning a person-centred approach.

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			acknowledged in the guidance. There is evidence that improving people's self-efficacy, confidence, skills and knowledge (patient activation[13]) can lead to improved health behaviours and clinical outcomes.[14] Self management support[15] provides a portfolio of techniques and tools that help patients choose healthy behaviours. It also transforms the patient-caregiver relationship into a collaborative partnership.[16],[17] We support the PDG observation that simply providing information isn't sufficient to effect a change in a person's behaviour. Evidence shows that proactive approaches that go beyond providing information and building technical skills are more likely to improve clinical outcomes.[18] A helpful summary of the type of self-management support that is most likely to lead to behaviour change is set out in our review of evidence.[19] In order to achieve this change, there needs to be a shift in approach from diagnosing and determining what people need to do to helping people identify their own motivations and to take steps to change their behaviour.[20] At the	Self-management did not feature in the evidence reviewed, as such we cannot make recommendations on this. We are unable to accept or review additional evidence at this stage.

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	Recommendations 10 and 15		heart of this is shared agenda setting, collaborative goal setting and health service follow-up on goals which in turn lead to better quality of life, more appropriate patterns of health service utilisation and better clinical outcomes. It is positive that the guidance addresses goal setting and goal follow up but it needs to start with the person's own agenda. Negotiating the agenda sets the tone for a partnership encounter and supports patients to consider both 'what matters to them' (their uninformed preferences) and 'what might matter to them' after negotiation with a professional (their 'informed preferences'). If the guidance does not reflect this, it risks reinforcing an approach where healthcare professionals continue to apply a traditional model of diagnosis/treatment compared with a more collaborative model that incorporates agenda setting, goal setting and goal follow up. In order to make this happen, professionals need to have the necessary skills, knowledge and confidence to engage people in agenda setting. We recommend that the guidance should explicitly include agenda setting before goal setting in both recommendations 10 and 15. We agree with the PDG that it is important that behaviour change programmes do not increase health inequalities. There is evidence that self management support programmes can be effective in reaching people who have lower levels of confidence, knowledge and skills than others with the same condition and from the hardest to reach groups that do not usually attend such programmes and in supporting them to change their behaviour.[21]	Thank you for your comment – agenda setting is integral to goal planning and setting.

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The Health Foundation			[8] Patient activation refers to a person‟s ability to manage their health and healthcare. As well as exhibiting general health-promoting behaviours, people with higher levels of activation are also more likely to adopt healthy behaviours. For instance, more-activated people with diabetes are more likely to keep a glucose journal and more-activated people with arthritis are more likely to exercise. Improved activation is therefore the first, pivotal step on the road to the optimal management of any long-term condition. [9] De Silva, D. *Helping people help themselves, a review of the evidence considering whether it is worthwhile to support self-management*, London: The Health Foundation; May 2011, p.18. (http://www.health.org.uk/publications/evidence-helping-people-help-themselves/) [10] Self management support is the assistance that caregivers – including doctors, nurses, other health professionals, peers, and family members – give to patients to help them manage their long-term condition in a way that improves their health and quality of life. [11] Bodenheimer T, MacGregor K, Shafiri C (2005). *Helping Patients Manage Their Chronic Conditions*. California: California Healthcare Foundation. [12] ‘Behind closed doors’ – an animation exploring what a change in the	Please note that we are unable to accept or review additional evidence at this stage.

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			relationship between patients and clinicians might look like (http://selfmanagementsupport.health.org.uk/) [13] De Silva, D. *Helping people help themselves, a review of the evidence considering whether it is worthwhile to support self-management*, London: The Health Foundation; May 2011. p.10. [14] Figure 1: continuum strategies to support self management, De Silva, D. *Helping people help themselves*, London: The Health Foundation; May 2011. p.viii. [15] 'Behind closed doors' – an animation exploring what a change in the relationship between patients and clinicians might look like (http://selfmanagementsupport.health.org.uk/) [16] *Co-creating Health: Evaluation of first phase*, London: The Health Foundation; April 2012, p.61.	
The Health Foundation	**General and 3.36**	**p.32**	***Supporting health professionals*** We welcome and strongly support the PDG's views on the importance of training. The attitudes and skills of healthcare providers can have a significant effect on the extent to which people feel engaged and supported to more effectively manage their health and care.[22] As identified above, the most effective self-management support requires a transformation in the patient-caregiver relationship. This isn't just about a	Thank you. Please see responses above.

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			toolkit of techniques that healthcare professionals use to try to influence changes in a person's behaviour. It requires a shift in mindset about the professional's role and objectives. We do not believe the recommendations in the guidance about training adequately address the training and support required to support this change. Training should support people to develop the skills to use the available tools. It also needs to go further to help professionals to practice a different role. Our Co-creating Health and MAGIC improvement programmes have demonstrated that role play is a necessary part of helping clinicians to behave differently.[23] Health and social care professionals need training and ongoing support to allow them to develop not just the knowledge and skills but also the confidence to support people to more effectively manage their health and care. Our Co-creating Health improvement programme teaches clinicians how to support self-management by incorporating three key processes or 'enablers' into their routine practice: o Shared agenda setting o Collaborative goal setting o Active follow up	

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	Recommendations 12 and 16		As outlined above, we believe these are key factors in supporting encouraging behaviour change for people living with long-term conditions. Training in these areas was shown to increase clinicians' confidence to use self-management support. It can also lead to a significant increase in the extent to which patients feeling supported in their efforts to self-manage and have confidence in their ability to change behaviour and carrying out agreed action plans.[24] We would reiterate our comments in the previous section that the guidance needs to incorporate these into any training recommendations. The guidance is largely silent on the post training support needs of professionals other than brief references to 'refresher training' (recommendation 12) and 'feedback' (recommendation 16). They need ongoing support to embed changes in their own practice to support behaviour change in patients. We have identified four key factors that help to encourage and support professionals to develop the necessary skills and confidence: - Targeting training sessions for whole teams. - Utilising senior clinicians to act as champions. - Providing post-training support. - Incorporating self-management support skills training in medical and healthcare education.[25] We welcome the current focus in the guidance on a simple typology of interventions (very brief, brief, and high intensity). However, in order for the	Re. post training support. The PDG did not take the view that the guidance is largely silent on post training support. Recommendations 2, 11 and 13 all highlight the need for on-going support in terms of training, mentoring and managerial support. Please note that Recommendations are written in a way to avoid repeating information in

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			guidance to be practically useful for commissioners and providers we believe that the PDG may wish to consider: • making the typology more explicit and referring to it as a matrix that could inform workforce training programmes • making broad recommendations about minimal skillsets for a range of professional groups (eg 'all GPs should be able to deliver a VBI, some will wish to extend their skillset to confidently deliver a BI'…etc) • referring to the fact that patients who are involved in risky behaviours should have access to an appropriately qualified professional (as per recommendation 7) • referring to the fact that CCGs and Health and Wellbeing Boards should commission a range of interventions that mutually reinforce (as per recommendation 1) • giving a concrete example of what such a strategic approach to supporting behaviour change might look like. For example: *MR X has COPD and continues to smoke 40 cigarettes per day. A series of very brief interventions by his GP leads Mr X to make an appointment to see the smoking cessation team. During the course of his work with the team, he sees another GP for a medication review. At that appointment, the GP uses the opportunity to deliver a very brief intervention regarding smoking cessation, thus reinforcing the work of the specialist intervention service*	other recommendations where possible. Thank you for your comments on the typology of interventions. Guidance follows a specific template that does not usually include diagrams, matrices, examples of case studies,etc. Please note that recommendation 13 does provide details of minimum training requirements for health and social care professionals. Please see Implementation tools that accompany this guidance for support.
The Health Foundation			[17] De De Silva, D. *Helping people help themselves, a review of the evidence considering whether it is worthwhile to support self-management*, London: The Health Foundation; May 2011. p.18. [18] The MAGIC Programme: Evaluation, London: The Health Foundation, April 2013, p. iii; *Co-creating Health: Evaluation of first phase*, London: The Health	Thank you. Please note that we are unable to accept or review additional evidence at this stage.

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			Foundation; April 2012, p.87. [19] *Co-creating Health: Evaluation of first phase*, London: The Health Foundation; April 2012, p.72. [20] Co-creating Health: Evaluation of second phase to be published early autumn 2013.We would be happy to share the results of this evaluation with NICE.	
The Health Foundation	**General**		***Implementation*** The guidance does not specify how the guidance will be implemented. Our Co-creating Health improvement programme has been testing a model based on three factors: - Self-management training for patients - Self-management support training for clinicians - Service improvement activities (to support and reinforce the first two elements). [26] As part of the programme we have been exploring how these three factors can be aligned. One of the main challenges can be in aligning system changes to support people to more effectively manage their health and their behaviours. Even if detailed guidance on implementation is outside the scope of this guidance, an acknowledgement of the importance of system drivers	Please see Implementation tools that accompany this guidance. Please note that we are unable to accept or review additional evidence at this stage.

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			and the difficulties in implementing change would be helpful. .	
The Health Foundation			[21] Co-creating Health: Evaluation of second phase to be published early autumn 2013, p.64.	Please note that we are unable to accept or review additional evidence at this stage.
The Royal College of Midwives	General		The Royal College of Midwives welcomes the draft of this important guideline and considers the majority of the content to be very helpful and relevant.	Thank you.
The Royal College of Midwives	Background	4	We are disappointed to see that breastfeeding is not included in the list of behaviour changes that are referred to here. Although breastfeeding is discussed in other NICE guidelines, it is important to include it here as well.	To ensure we can comprehensively cover a topic within the time and resources available, we have to set certain limits to the behaviours that can be covered. As you note, other NICE guidance is available that covers breast feeding.
The Royal College of Midwives	Recommendation 2	6	'Health equity audit' needs a clear definition, or a link to find an example.	Thank you – please note there is a link: http://publications.nice.org.uk/health-inequalities-and-population-health-phb4/glossary#health-equity-audit
The Royal College of Midwives	Recommendatio	7	The recommendation that 'data should be made available to local and national	Thank you for your

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	n 2		organisations to aid monitoring' is important but it would be helpful if there was a discussion about whether this should be freely available, or whether there is an expected cost.	comment. The recommendation is that this is in service specifications, and therefore part of a contract to provide a service.
The Royal College of Midwives	Recommendation 3	7	We are very pleased to see the vital recommendations - to ensure funds are available for independent evaluation of the service and - to disinvest in programmes that are not effective.	Thank you.
The Royal College of Midwives	Recommendation 3	7	It would be useful to recommend a frequency for 'quality assurance checks'	Thank you but this is not possible, we have recommended that the frequency of quality assurance checks is detailed.
The Royal College of Midwives	Recommendation 4	8	Managers reviewing 'job descriptions to ensure they include behaviour change knowledge and skills' is surely aspirational and unlikely to be carried out within current resources.	Thank you for your comment. Job descriptions should reflect what a person is expected to do as part of their job role. Reviewing job descriptions is a common practice, the recommendation is not prescriptive about how often this should happen.
The Royal College of Midwives	Recommendation 6	11	Putting details in a manual from 'the intervention protocol' is likely to be limited by ownership of intellectual property if the intervention is undergoing	Thank you. Recommendation 6 has

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			evaluation.	been amended to highlight that copyright details should be added to manuals.
The Royal College of Midwives	Recommendation 6	11	It would be more helpful to include a discussion of the wider choice of options here, rather than a repeated focus on the 'logic model' alone.	Thank you for your comment, however the logic model is provided as an example only (as written) and has only appeared once in the recommendations.
The Royal College of Midwives	Recommendation 7	12	We are very concerned about 'the very brief' and 'brief' interventions described here, and think that these initial meetings should consist of a referral to the appropriate behaviour change specialist. Inappropriate interventions can be more damaging than helpful.	Thank you for your comment. Please see glossary definitions - A very brief intervention includes signposting to a service and a brief intervention may also involve referral. Training should ensure interventions are appropriate. Recommendation 8 addresses appropriateness of referrals.
The Royal College of Midwives	Recommendation 7	12	We do not understand the relevance of including 'ethnicity or family history' here as these are factors that cannot be changed.	Ethnicity and family history can put someone at a higher risk of a health-related condition.

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				It is to ensure these are taken into account when thinking about health (for example see recent NICE guidance on BMI and waist circumference - black, Asian and minority ethnic groups (PH46). The wording has been changed to '(The risk could be due to current behaviours, sociodemographic characteristics or family history.)'
The Royal College of Midwives	Recommendation 10	15	'Social support'. There should be a definition of 'reward' in this context.	Thank you for your comment. Reward is separate from social support.
The Royal College of Psychiatrists	9	P. 50	A main concern is the way the authors have mischaracterised a large body of research based in Motivational Interviewing (MI). The review seems over-reliant on one particular theoretical orientation (behavioural medicine) and seems to have sidelined much high quality international research on MI. There are over 200 Randomised Control Trials of MI and several good meta-analyses, as well as a small but growing literature on process issues in MI sessions, relating them to mechanisms of change. This is not sufficiently reflected in the document.	Your concerns have been noted. The approach taken in the evidence review was in line with the scope for the partial update, including a focus on behaviour change techniques. Systematic reviews and RCTs

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				of motivational interviewing cited by existing NICE public health guidance have been considered as part of review 1. RCTs of motivational interviewing have been included in review 2 where they met inclusion criteria. Systematic reviews were not included in review 2. One of the difficulties for the review team has been the lack of detail in published papers on what constitutes motivational interviewing. Please note that Motivational interviewing is not a specific technique but made up of several behaviour change techniques (BCT as defined in this guidance - see glossary). One of the difficulties for the review team has been the lack of detail in published papers on what constitutes motivational interviewing. Please see the considerations section for further details on this.
The Royal College of Psychiatrists	9	P. 52.	The guidance refers to MI as being poorly defined. There are very clear definitions in all three editions of Miller and Rollnick 'Motivational Interviewing:	Please note that it is not the guidance which says

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			Helping People Change', though the most up to date discussion is to be found in the third edition (2013).	MI is poorly defined, this is from the evidence statement 1.7 (i.e. from the externally commissioned review 1). The authors of the review have re-worded the evidence statement to make it clear that it is not the term that is poorly defined but that the guidance/papers that claim to use the MI do not provide sufficient details to identify component techniques.
The Royal College of Psychiatrists	9	P. 52.	The document classifies MI as 'a means of persuasion'. This is a very fundamental error: MI is antithetical to persuasion. MI is drawn in part from a tradition of client centred practice where the aim is often one of client actualisation, the belief that the client has in him or herself the resources for change and at some level knows what is best for him or herself. Persuasion runs counter to this belief because it implicitly requires that 'doctor (or other clinician) knows best'. This error may possibly reflect a lack of understanding or awareness of a large body of research on change processes in MI. This guidance would be improved greatly if it considered a wider range of approaches, and avoided relying too heavily on a behaviourist approach.	Thank you for your comment. This appears to be in relation to the wording in evidence statement 1.7. Please note that although motivational interviewing may not involve persuasion as the term is commonly defined, the definition of the Intervention Function "Persuasion" does not carry the same

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				connotations. As an Intervention Function it is defined as: "Using communication to induce positive or negative feelings, or to stimulate action". The example provided for this is "Using imagery to motivate increases in physical activity". Based on this definition it was the intervention function which best fit the concept of motivational interviewing as described in evidence for the review. The evidence statement has been reworded as follows to: "The content of motivational interviewing was often described in only limited detail in the guidance and evidence tables. Based on the detail provided it best matched

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				Intervention Function 2 Persuasion (defined as "Using communication to induce positive or negative feelings, or to stimulate action")."
The Royal College of Psychiatrists	9	P. 50.	There seems to be little engagement with the large and growing body of evidence for MI in health behaviour change. The most recent meta-analysis cited is 2001, whereas at least three have been published since then, including one by Cochrane.	Systematic reviews and RCTs of motivational interviewing cited by existing NICE public health guidance have been considered as part of review 1. RCTs of motivational interviewing have been included in review 2 where they met inclusion criteria. Systematic reviews were not included in review 2. Please see consideration 4.27.
University of East Anglia	2	6	One very easy way to improve diet is to provide compulsory cookery lessons at school and link diet with health and exercise.	Thank you for your comment. Evidence on the effectiveness of cookery lessons delivered in schools was not subject to our review process and so we are not able to make recommendations concerning them. They

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				would also be out of scope if they are delivered to under 16s.
University of East Anglia	3	7	There is a very good review showing that interventions need to be long term (Chapman 2010). Many are just short-term and people soon fall back to their old ways.	Thank you. Please note that we cannot look at additional evidence at this stage.
University of East Anglia	3	7	From my own research, many people do not have the knowledge and skills to cook healthy meals using cheap ingredients, which links back to my first comment. Howard Wilsher (in prep).	Thank you.
University of East Anglia	3	7	Young people have less knowledge and cooking skills and resort to convenience foods.	Thank you for your comment.
University of East Anglia	3	7	Personality may also be a factor. Evidence is building to suggest conscientiousness and emotional stability are important. This means there would need to be personalised interventions such as cognitive behavioural interventions to make permanent changes.	Thank you for your comment.
University of East Anglia	3	7	Evidence also suggests that personality may be reliant on working memory capacity. Better training in early school may improve many areas of health.	Thank you for your comment. Please note this guidance does not cover recommendations for under 16s.
University of East Anglia	4	8	Staff involved in interventions need to have full skills not just trained to apply the intervention. I.E. Qualified chefs. These people have high level of skills to provide the basics and how to develop these. In my own research fruit and vegetable consumption was over 5 a day for those who had access to training or social support from people with catering training.	Thank you for your comment. There are recommendations concerning training in this guidance which highlight the importance of skills.
University of East Anglia	5	9	See above –free training to develop good skills are required.	Thank you for your

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				comment. It is up to providers to decide on whether or not they charge for training; and we are not sure how this fits with this recommendation.
University of East Anglia	5	9	Providing training on diet, exercise and health would be generic to target all groups rather than tailor to specific groups. Need personalised interventions.	This recommendation concerns broad principles of what to consider when planning an individual-level intervention. Details on tailoring to personal needs is in recommendation 8.
University of East Anglia	6	10	Evidence on which to design interventions is low –see comment 2.	Thank you for your comment but it is not clear what you are suggesting should be changed.
University of East Anglia	7	12	See comment 2 –any intervention needs to be long, brief interventions do not work and therefore, not cost effective.	These recommendations are based on reviews covering many studies.
University of East Anglia	9	14	There are several comments addressing tailoring of needs, but personalised training may be needed and perhaps not just behavioural.	Thank you for your comment but we are not sure what change you are suggesting.
University of East Anglia	10	15	Many interventions in social settings may help behaviour change, however, duration and continuation are important.. Research suggests social factors are	Thank you for your comments. These

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			not as important as individual factors such as personality and self-efficacy. The meal provider may try to initiate change but can be thwarted by individual factors from family members.	techniques are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific techniques is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence and is discussed in the consideration.
University of East Anglia	11	15	Interventions need to be long-term, over one year to have any effect.	Thank you for your comment.
University of East Anglia	12	16	See point 7 – trainers must have excellent skills knowledge to be effective for long-term change.	Thank you for your comment.
University of East Anglia	13 and 14	18	See above and point 1.	Please see response above.
University of East Anglia	15	19	Trainers should have cognitive behaviour therapy skills or motivational interviewing or be able to refer people in need of this training.	Thank you for your comments. These skills are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific skills is highlighted in a linked

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				document (previously in section 9 of the draft guidance) which links recommendations to the evidence
University of East Anglia	16	20	Agreed there should be monitoring however, if trainers are allowed to develop interventions, being monitored might inhibit good practice.	Thank you for your comment. The PDG considered the issue of assessment carefully, but did not agree that assessment should inhibit good practice and felt that the advantages of assessment outweighed any potential negative impact.
University of East Anglia		26	Statistical meta-analyses miss lots of data. It is essential to have qualitative methods and evaluations. My research synthesis on fruit and vegetable consumption in adults raised barriers not found in quantitative research- taste, texture, satiety, role of women as meal provider.	Please note that review 3 is a review of qualitative research.
University of East Anglia		32	Ripple effect may work in some areas but I do not think it will work well on dietary change where good knowledge and skills are required.	Thank you. We are not sure what aspect of this section the comment is referring to. If it is about 3.36 in the draft guidance (now 4.45), this is not about a ripple effect of knowledge being passed down, but about the potential

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				impact of training i.e. the potential number of final beneficiaries who could improve their behaviour as a result of knowledge and skills imparted by appropriately trained practitioners
University of East Anglia	general		Interventions could encourage work places to offer healthy packages in terms of diet and exercise. Where there is such support changes take place and are more likely to be adhered to.	Thank you for your comment. Recommendation 2 on organisational support recommends behaviour change services are made available to staff.
University of Exeter Medical School	Overall comment	n/a	The University of Exeter Medical School welcomes this updated NICE guidance and broadly supports the recommendations. The collated comments of UEMS staff are represented below.	Thank you.
University of Exeter Medical School	Recc 2: What action should they take, para 1	6	Could add another bullet here … "- Content " (and draw some text from NICE guidance on recommended intervention content in relation to obesity, PA, diabetes prevention etc)	Content of interventions is described in recommendations 5 and 6. Given the number of relevant NICE guidance to this behaviour change guidance it was decided to limit reference other guidance throughout as this may add a level of complexity that confuses the reader – we do

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				however, highlight that behaviour specific detail can be found in other guidance.
University of Exeter Medical School	Last para on page	6	Re: "They should also include strategies to address relapse " – such as? Perhaps identification of potential barriers and ideas for overcoming any anticipated problems.	This is addressed in recommendations 7 and 10. Please note that all the recommendations in the guidance should be looked at together rather than in isolation; and Recommendations are written in a way to avoid repeating information in other recommendations where possible.
University of Exeter Medical School	Recc 4, last para	9	There may be some value in collecting data on more than just behaviours – for instance recording of main reason for wanting to change and any goals for change that are set would be useful to allow follow-up at a later time (especially if the person following the patient up is not the same as the one who started the process).	Thank you for your comment. Please note that the recommendation on evaluation provides more detail.
University of Exeter Medical School	Recc 7	8,last para	A classic high risk state requiring more specialist intervention is 'high risk of developing type 2 diabetes' (you could cite PH38 again here)) –this is probably more pertinent (and more common) than BMI >40	Thank you for your suggestion, however the PDG were content to keep the example of BMI >40.
University of Exeter Medical School	Recc 10	15	Problem-solving should be in there as a key element of self-regulation – it seems odd to include all the other self-regulation techniques but not this critical one (self-regulation = learning from experience and this is strongly enhanced by problem-solving). By problem-solving, what is meant is, during a review of progress /when the person encounters setbacks (not achieving their	Thank you for your comments. These techniques are highlighted as these are the ones for which there

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			goals), identifying what stopped then from succeeding and then identifying solutions to the problem. It is like a coping plan, but conducted post the behavioural attempt rather than at the planning stage. So, the suggestion is to add 'problem-solving' under the 'Feedback and monitoring' section. This would also be consistent with text (and evidence) in PH38 (and with recommendation 15 in the current guidance)	is good evidence of effectiveness. The evidence base for these specific techniques is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence and is discussed in the consideration.
University of Exeter Medical School	Recc 11	16	In Behavioural Activation therapy (which has a good evidence base for relieving depression by getting people more behaviourally active in general), to encourage maintenance of behaviour change, the participant is encouraged to focus on making changes that are Routine, Pleasurable or Necessary. It would be a good idea to add some consideration of "enjoyment" at least when considering which changes to make - if you can find a lifestyle that is both healthy and enjoyable, it is much more likely to be sustainable. It is suggested here (and could be made more explicit) that, for some behaviours that are incremental in nature a series of small changes (e.g. to diet or physical activity) might be more sustainable than attempts to make radical changes. There is not much specific evidence to support this though (expert opinion only)	Thank you for your comments. These techniques are highlighted as these are the ones for which there is good evidence of effectiveness.
University of Exeter Medical School	Recc 13, 'who should take action'	17	Add Medical Schools (they need a specific kick to do this!) Also training organisations (e.g. Education for Health) And private sector health care providers (for their own staff)?	Thank you f or your comment. Please note that medical schools are covered under 'schools'. We think that the

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				wording covers all those who provide training to health and social care professionals: 'Royal colleges, faculties, schools, voluntary sector and sector skills councils that train or accredit health and social care professionals.'
University of Exeter Medical School	Recc 15	19	"rapport and relationship-building " is the same as 'developing empathy using reflective listening and empathy' so maybe could combine these two items – e.g. 'developing rapport and motivation through reflective listening and other empathy-building techniques '. (other techniques include e-p-e for information-exchange; using a guiding style of communication; open-ended questions, affirmation (especially of patient autonomy); and summaries) There are of course other techniques for building motivation (building illness model; weighing up the pros and cons; examining possible futures etc)	Thank you for your comment but we do not agree that "rapport and relationship-building " are the same as 'developing motivation through reflective listening and empathy' as the latter is highlighting the need to develop motivation,and how this can be achieved while the former is about relationship building.
University of Exeter Medical School	Recc 15	20	Another important group facilitation skill is maximising inclusion of /seeking contribution from all group members Also "encouraging sharing of ideas between group members"	Thank you for your comments. The skills in this recommendation are the ones for which there is good evidence of

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				effectiveness. The evidence base for these specific skills is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence
University of Exeter Medical School	Recc 17	21	Seek to make comparison of outcomes with either another group (ideally using randomisation), or with a benchmark standard (e.g. the performance of a high performing intervention which has been subjected to a high quality RCT). Benchmarking to a gold-standard is a key principle of clinical audit NB: you won't get "effectiveness" or "cost-effectiveness" data outside of a high quality RCT, so be careful with the terminology here (not sure that most H&WB boards are able to undertake this type of evaluation, although it has been known (Jolly et al, BMJ, 2011; 343:d6500)	Thank you for your comment. We have provided the link to the Medical Research Council guidance on the development, evaluation and implementation of complex interventions to improve health for those who require further information on this. While RCTs are seen as the 'gold standard' there are other study designs that can provide effectiveness data.
University of Exeter Medical School	Recc 18, Who?	22	Could add Dept of Health; Royal Colleges and other national level professional bodies	Thank you for your suggestion. A list of example organisations who should take action is

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				provided.
University of Exeter Medical School	Recc 18, Who?	22	VERY good idea to establish a national repository – perhaps for intervention manuals and examples of individual behaviour change techniques, as well, rather than just for training curricula?	Thank you. NICE Evidence is a repository for evidence on all health and public health interventions, including behaviour change interventions.
University of Exeter Medical School	3.14	28	A bit of over-claiming here? I would suggest a re-word to " The PDG noted that behaviour-change interventions aimed at alcohol use, eating patterns, physical activity, sexual behaviour, smoking and multiple health behaviours, that have been subjected to research, are generally cost effective." There are a lot of ineffective, non-professionally developed low quality interventions out there (and in the literature – the main characteristic of most reviews of BC interventions is *massive variation in effectiveness* – we wouldn't want readers to think that anything is likely to work here.	Thank you. Your suggestion has been reflected in the re-drafting of the consideration.
University of Exeter Medical School	3.15	28	"interventions that target many levels simultaneously tend to be the most effective. " Is there any robust evidence for this statement?. It sounds plausible, but perhaps you should be more cautious in the language used here?	Thank you for your comment. The PDG felt this is an accurate statement. 'tend to be' indicates this is not always the case.
University of Exeter Medical School	3.21	29	Could you provide a practical definition of 'long term'? perhaps 12 months or (ideally) more	Thank you for your comment. Recommendation 10 highlights the importance of maintaining change – deemed as behaviour change for more than 1 year. Please note that considerations are not recommendations but

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				reflect the deliberations of the PDG during the guidance development process.
University of Exeter Medical School	3.25	30	The issue here is much more about "how it is delivered" than "who is delivering it". There is plenty of evidence that interventions can be effectively delivered by a wide range of individuals and professional groups (Greaves et al, 2011 BMC Public Health). However, delivery style is a key mediator of effectiveness (e.g. Denford S et al, Health Psychology, In Press 2013) – individual tailoring and using a patient-centred /guiding style (e.g. Motivational Interviewing) are good examples of this.	Thank you for your comment. The consideration is in line with your comments. It highlights competencies and how something is delivered.
University of Exeter Medical School	3.28	30	Add tools for PA assessment of likely sedentariness (GPAQ) as recommended in recent NICE guidance on PA	Thank you for your comment. We are unable to provide exhaustive lists as examples and have reminded readers to review topic specific guidance for detailed recommendations the content of interventions of specific behaviours and/or groups.
University of Exeter Medical School	3.33 (and elsewhere where social support is mentioned)	31	NB: Social support is not always positive – other people can often be counter-productive – you could rephrase along the lines of 'managing social influences' (i.e. reducing the impact of negative social influences and enhancing the impact of positive social influences) rather than aiming to increase social interaction or 'social support' per se.	Thank you. Your suggestion has been reflected in the re-drafting of the consideration.
University of Exeter Medical School	Reccs for Research	34	The following is factually wrong – please edit accordingly "It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect." This is wrong: E and CE are	Thank you for your comment. This is standard text for public

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			entirely different and cannot be conceptually combined – you can have E without CE for instance. Much safer /more accurate to say "E and CE" throughout instead of just "E".	health guidance and is not subject to change. The statement is saying that where the term 'effectiveness' is used, that we also mean cost effectiveness. It is not saying they are the same.
University of Exeter Medical School	4.1	34	Why not diet also? Why not sexual health behaviours? The HTA PCCPI panel might well take up some of these recommendations, so this is important	There is evidence concerning diet but it has not yet been synthesised. Please see considerations. Sexual health has been added.
University of Exeter Medical School	4 (reccs for Research	34, 35	More research is also needed on the use of emotional self-regulation (e.g. using techniques to monitor impulses and improve impulse-control, as well as to manage stress-induced eating behaviour. Collins RL. Relapse Prevention for Eating Disorders and Obesity. In: Marlatt GA, Donovan DM, editors. Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. 2nd Edition ed. New York: Guildford Press; 2008.) More research is also suggested on the use of mobile phone or internet based software to support longer-term behaviour change More research is also suggested on which combinations of behaviour-change techniques are effective and cost effective for supporting *maintenance* of behaviour change (smoking, higher-risk and increased-risk drinking, diet, physical activity and sexual behaviour). (NB: The House of Lords select Committee on Behaviour Change also recommended this).	Thank you for your comment We are limited in the number of recommendations for research we are able to provide details on, and those included are the one's prioritised by the committee. However, additional gaps in the literature are highlighted in this section of the guidance that have been

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				raised following review of the evidence that informed the guidance.
Weight Concern	General – training staff on principles of behaviour change		This has now been cited by a number of reports including the recent Academy of Medical Royal Colleges which discussed the need for those dealing with weight loss to be trained in motivational interviewing principles. Whilst I completely agree with this in principle, I think NICE or PHE etc. should provide a list of recommended courses or direct people as to where to find these training courses.	Thank you for your comment. We are not able to recommend specific courses for motivational interviewing as the PDG have not seen evidence on the appropriateness of these courses.
Weight Concern	Comment on making intervention materials 'freely available'		This may be problematic for a number of reasons as those providing commissioned services will not want to 'freely' make this information available. Outlining the principles of behaviour change is not a problem, I believe that should be clear, and It will be transparent if a person was to be trained to deliver the programme, but the full programme content for many programmes cannot be made freely available or the public would access it without the need to go on the course/weight management intervention.	Thank you for your comment. The recommendation has been amended to highlight the need to provide copyright details and 'training before use' requirements in manuals.
Weight Concern	Recommendation 13		Should this not relate to any staff working in this area?	No, this is specifically for health and social care training, as stated in the recommendation title.
Weight Watchers UK	General		**Practical Summary needed up front -** Weight Watchers welcomes the updated draft guidance from NICE on behaviour change. This will be massively helpful in a field which is dogged by confusion, mixed terminology and jargon. The draft guidance holds a wealth of key points which arise from the PDG's detailed evaluation of the evidence on behavioural change	Thank you for your comments. Guidance is written to a standard format. All

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			techniques (BCTs) in alcohol, diet, smoking, physical activity and sexual health interventions. However, the important nuggets of information are currently lost within the text and are difficult to access – especially when the audience groups for which this guidance is directed at, are currently bombarded with swathes of information as a result of the public health reforms. We suggest including a 2 page summary at the front of the document which contains between 10-12 major take home messages emerging from the review of the evidence on BCTs undertaken by NICE. Although we understand that a separate summary document will be prepared, we still feel that a summary section to open the full guidance would still be highly useful.	recommendations are important and the guidance should be read as a whole.
Weight Watchers UK	General		**More emphasis on scaling up behaviour change programmes –** Unhealthy behaviours are widespread. For example, currently two thirds of adults are overweight or obese as a result of poor eating habits and inadequate physical activity. An industrial scale service response is needed. Scratching the surface of the problem by providing services for a handful of adults in England will have little or no population impact. However, experience drawn from Weight Watchers partnerships with health agencies in the UK suggests that commissioning of the necessary behaviour change services is either static or decreasing. This could be for a number of reasons. The new commissioning architecture is taking time to settle and responsibilities for commissioning behavioural change interventions remain unclear, Additionally Local Authorities appear not to have the funding, or are unable to prioritise funding for such services. Indeed, Local Authorities are currently undergoing crippling funding cuts. Given this reality of front line service provision, NICE's draft guidance is unlikely to have any impact and its recommendations become merely academic. Weight Watchers suggests that this context should be acknowledged within the guidance in order to ground it in the real world. Are there any recommendations that can be made around scalability, funding	Thank you for your comment. This seems to relate to community or population level interventions which are out of scope for this current guidance. We make recommendations concerning commissioning. Recommendations on commissioning structure are not appropriate for this guidance.

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			imperatives and commissioning architecture?	
Weight Watchers UK	General		**Stronger endorsement of usage of Michie's taxonomy -** Behavioural change is one of the 4 pillars of Weight Watchers programme, which has been shown to be effective in helping people control their weight (Heshka at al 2003, Jolly et al 2011, Jebb et al 2011). Weight Watchers 1,800 leaders are trained to deliver and facilitate a range of BCTs, where goal setting and planning, feedback and monitoring and social support are central. In addition Weight Watchers methodology is based in incorporating a wide range of BCTs. Weight Watchers are able to classify and describe the individual BCTs employed in the programme against the taxonomy developed by Michie (Michie et al 2011). Yet this is not a common language in the field on obesity interventions which seek to change lifestyle behaviours. Indeed there is much confusion, and lack of detail on the specific types of BCTs used. Much stronger endorsement of Michie's taxonomy is needed to ensure a consistency of terminology around BCTs interventions in public health in the future. NICE's updated guidance on behaviour change provides a perfect platform to do this.	The recommendations are clear that behaviour change techniques should be described, for example using a taxonomy (recommendation 6) and this would include Michie et al.'s taxonomy.
Weight Watchers UK	General		**More encouragement to use/buy in existing services with proven effectiveness and established outcomes** – There is a multitude of existing behavioural change services which target adult obesity. However, presently there is strong emphasis within NICEs draft guidance on developing services (particularly recommendations 5 and 6). To develop evidence based lifestyle weight management services from scratch requires massive investment, research, capabilities and capacity. Public health interventions need to deliver outcomes and it is of course a balance between encouraging innovation and delivering patient outcomes to reap the benefits of investment. Surely in this financially challenging public health environment where budgets for services	Recommendation 3 on commissioning states 'Commission interventions that are proven to be effective at changing and maintaining behaviour change'. i.e. this would include existing services with proven

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			are extremely limited and efficiency savings are of paramount importance then emphasis within the guidance should not be on re-inventing the wheel – but commissioning existing services with proven effectiveness and then placing investment in tailoring these to local needs. This should be included in the guidance, indeed a recommendation on commissioning behaviour change services would be a valuable addition and help to balance the view between 'do it yourself' vs 'refer to a provider'.	effectiveness. Recommendations 5 and 6 are about the development and design of planning interventions/programmes; and do not indicate that new services have to be developed.
Weight Watchers UK	General		**Weight Watchers welcomes inclusion and recognition of the value of qualitative data -** Weight Watchers has consistently commissioned a raft of complementary qualitative and quantitative studies to understand and improve the workings and effectiveness of its behavioural change programme. These qualitative studies have provided a wealth of insight into client experience of the programme and helped to inform how to tailor specific elements to different target groups. In the past, these types of descriptive studies have been reluctantly accepted as part of the evidence underpinning weight management services, when in reality they are vital to understanding how to maximise the effectiveness of these services and interventions. Weight Watchers is pleased to see that NICE has formally recognised these types of studies within the present draft guidance.	Thank you.
Weight Watchers UK	General		**Stronger messaging over the cost effectiveness of BCTs -** Criticism is often levelled at behavioural change programmes that they are expensive, resource intensive and less cost effective relative to environmental interventions which seek to change the context and climate surrounding the	Thank you for your comment Please note that there is, in general, evidence of

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			decisions which people make.. After considerable review of the evidence NICE have concluded that BCTs are cost effective. This is a crucially important conclusion to inform decision making at local level. However, currently this fundamental conclusion is lost within the text. Weight Watchers suggests that more emphasis/prominence is given to this point. Given the extreme financial situation that national health and public health services are currently facing, clear and strong cost effectiveness and ROI messages are much needed for local commissioners to be able to win monies to commission services that meet these NICE guidance.	cost effectiveness for behaviour change interventions that have also been shown to be effective. But there is little or no consistent association between the presence of any one behaviour change technique (or cluster of techniques) and an intervention being cost effective. NICE recognise the need for clear return on investment information for service commissioning and have a separate project in development for this http://www.nice.org.uk/usingguidance/implementationtools/returnoninvesment/TobaccoROITool.jsp New and updated tools are currently in development.
Weight Watchers UK	General		**Inclusion of table summarising different theoretical models underpinning Behavioural Change Interventions-** Weight Watchers suggests including a brief table summarising the different theoretical models	Thank you for your suggestion but NICE public health guidance

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			which are currently used to underpin behavioural change interventions. This would help non-specialists understand the text within the draft guidance and references to the theoretical basis.	conforms to a specific template that does not usually include Tables which summarise evidence.
Weight Watchers UK	General		**More emphasis on outcomes –** throughout the document there is a lack of clarity between behavioural change outcomes of patients / populations and process KPIs. We suggest that the guidance is reviewed with a focus on achieving patient / population based behaviour change outcomes. For example within recommendation 1 'identify the behaviours that the programme will address…' could be revised to 'identify the behavioural outcomes that the programme will deliver….'. For example within recommendation 5 'take into account the objectives of the intervention or programme', could be revised to 'take into account the desired outcomes of the intervention or programme'.	Thank you. Your suggestion to highlight outcomes has been reflected in the re-drafting of the recommendations.
Weight Watchers UK	General		**The guidance needs to acknowledge the challenge of demonstrating long term behaviour change and be less ambiguous –** The draft guidance indication that 'long term' equates to 'more than 1 year' is currently far too ambiguous. Guidance like this needs to be specific to the intervention and behaviour change that the interventions are working to instil; for example a 'long term' outcome from an obesity intervention is currently classed as 12 months. There needs to be some acknowledgment that collecting data on participants who have gone through a behaviour change intervention (which needs to be both non-completers and completers), is a challenge. Inevitably there will be loss to follow up.	Thank you for your comment. Long-term as over 1 year is what was set in the original guidance. We need to be consistent across behaviours about what we mean by long term. Recommendation 10 provides recommendations on supporting people in the long-term. The costing statement that accompanies this

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				guidance notes the difficulties in follow-up of participants.
Weight Watchers UK	General		Service providers of behavioural change interventions are part of the provider mix. At present this guidance is written in a rather NHS focused view, perhaps reflecting our past health service landscape. It would be a valuable exercise to reflect on the guidance in terms of the language used, to ensure that referral to service providers are part of the mix. For example, recommendation 8 suggests; 'before starting an intervention, assess the person's physical and mental health….'., could be adapted to 'before referring participants to an intervention, or starting an intervention, assess the persons…..'. there needs to be clearer definition between what is expected of those with clinical responsibility of patients and those who are providing intensive behavioural change interventions or programmes, where suitable. For example, through the training recommendations, there is no language that relates to 'providers of behaviour change interventions'.	Thank you for your comment. Please note that the guidance is edited to ensure it is accessible to as large an audience as possible and written in plain Englsh where possible. The change you suggest does not change the meaning of what is written; and regardless of whether someone is in the NHS or not they have a duty to ensure any intervention does not compromise someone's health.
Weight Watchers UK	General		Better distinction between 'brief, moderate and high' intensity interventions would be helpful. If this is made, then guidance could be better related to the different levels of interventions – at present all levels are 'lumped' into together, which does not make understanding and implementation as clear as it could be.	These terms are defined in the glossary.
Weight Watchers UK	Introduction	1	First bullet point – spell out that BCTs for individual level interventions encompass those delivered one to one and in group settings. Currently this is not clear.	Thank you. Your suggestion has been reflected in the re-drafting of the

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				glossary definition for individual-level interventions which now states: 'It can be delivered on a one-to-one, group or remote basis, but the focus is on creating measurable change in a specific person.'
Weight Watchers UK	Recommendation 1	5	9 lines down – define what is meant by an 'evidence –based programme'	Please note that this guidance is not intended as a guide on how to undertake or interpret research. Implementation tools that accompany this guidance include a Podcast on how to recognise and use good quality evidence in public health.
Weight Watchers UK	Recommendation 1	5	What action should they take – second bullet point. Weight Watchers suggests that this should read 'Ensure the **affordable** strategy meets local needs, identified through joint strategic needs assessments (JSNAs) and other local data.	Thank you for your suggestion /. Local and health authorities are constantly reviewing budgets and return on investment, and use NICE guidance to help identify cost effective interventions. The PDG developed the guidance with an assumption that

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				'affordability', or efficiency / cost effectiveness, will be a key concern.
Weight Watchers UK	Recommendation 3 & 17		We recommend that the guidance clarify what 'independent evaluation' is. In addition, recommend that evaluation is planned up front.	Thank you – independent evaluation has been added to the glossary and your latter point is addressed in recommendation 6 on designing: include a monitoring and evaluation plan and recommendation 16 on evaluation.
Weight Watchers UK	Recommendation 3		It is recommended that the team re-look at what it meant by the sentence ' maximises health outcomes…'. If health outcomes are going to be tracked and evaluated, this adds an additional layer of complexity and cost, in addition health outcomes must be intrinsic to the outcomes of the intervention. It is questioned if this sentence could say 'maximises the desired behavioural change outcomes…'?	Thank you. Your suggestion has been reflected in the re-drafting of the recommendation.
Weight Watchers UK	Recommendation 4		There seems to be an omission to this section, which is about providing adequate funding and resources in order to support behaviour change interventions and programmes. From Weight Watchers experience 'at the coal face' of commissioning lifestyle weight management services across the country, adequate funding in order to commission the scale and quality of services needed for local populations is absolutely the biggest barrier to delivery of services.	Please note that funding has been discussed in the previous recommendation.

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Weight Watchers UK	Recommendation 5	9	What action should they take? Weight Watchers suggests that the emphasis should be on working together to identify existing behavioural change interventions with proven effectiveness rather than co-producing interventions and programmes.	Thank you for your comment. Other recommendations make it clear that interventions with proven effectiveness should be commissioned (e.g. see rec 3). The recommendations on co-production are about working together to ensure an intervention is accessible, acceptable, feasible and sustainable. This is not at odds with selecting interventions with proven effectiveness.
Weight Watchers UK	Recommendation 5		Weight Watchers suggests that there needs to be an emphasis on planning based on the scale of behaviour change interventions and programmes required for equal access of local populations. The 'take into account' list feels very 'light'. It is a useful approach to be used as a checklist, but this is not an exhaustive list (for example it does not include anything about evaluation). Weight Watchers recommends that it is transformed into a useful full checklist that reflects the whole guidance, or that this section acknowledges that it is not an exhaustive list (as it may be taken as such).	Thank you for your comment. Please note that all the recommendations in the guidance should be looked at together rather than in isolation, issues around equal access and scale are within the recommendations for this guidance.

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				Evaluation plans have been added to the recommendation (and are in recommendation 16).
Weight Watchers UK	Recommendation 6	11	Second bullet point – suggest that when describing in detail the principles on which the behavioural change intervention is based, should also include the theoretical basis of the behavioural change programme.	Thank you for your comment. The PDG were of the opinion that 'mechanisms of action' is key rather than stating a specific theoretical basis.
Weight Watchers UK	Recommendation 10	15	Under 'goals and planning' – suggest that emphasis should be on practitioner facilitating client to set their own goals and develop their own action plans, coping plans and review these together. All the literature suggests that BCTs should be client lead rather than practitioner lead. This section feels very 'light'. A missed opportunity to demonstrate the range of BCTs. It is unclear what this list is; is it an exhaustive list of those BCTs deemed 'essential' to an intervention, or is this a list of some suggestions of BCTs that may be included. Clarity is needed here.	Thank you. Your suggestion concerning a client-led approach has been reflected in changes to the recommendation. Thank you for your comments. These techniques are highlighted as these are the ones for which there is good evidence of effectiveness. The evidence base for these specific techniques is highlighted in a linked document (previously in section 9 of the draft guidance) which links recommendations to the evidence and is discussed in the considerations (4.39-4.42). It

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				is also recommended 'Consider using other evidence-based behaviour change techniques that may also be effective.'
Weight Watchers UK	Recommendation 11	16	First bullet point last indent note – here NICE notes that people who make least change to everyday practices and routines are likely to be the most successful. However based on Weight Watchers experiences and insights we know that the level of behavioural change which overweight and obese people (now the norm in the UK) need to make to lose even 5% of body weight per week and then bring their weight down to a healthy BMI of 25kg/m² is significant. Our qualitative data confirms this and even people who are motivated to lose weight for their health perceive the level of effort they need to make is huge. For example, it is pretty easy to set a goal to change whole milk to semi skimmed and make some calorie savings and this is a behavioural change which is easy to sustain – but in weight loss terms this is a drop in the ocean. It is acknowledge that every little step is in the right direction. Some form of words needs to be included to help readers understand the reality of the level of behavioural change in order to achieve the desired health impact.	Thank you for your comment. This has been re-worded for clarity to 'note that small, manageable changes to daily routine are most likely to be maintained' – this is about maintaining a change in behaviour.
Weight Watchers UK	Recommendation 12	17	Fourth bullet point down – suggest inclusion of words * Ensure training is evaluated in terms of outcomes (learner performance post training) and process (did the training work well?)	Thank you for your suggestions. We think you are referring to the final bullet point. 'outcomes' and 'process' have been added and reference to relevant recommendations where further details can be found.

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Weight Watchers UK	Recommendation 15	20	Second bullet point down. Ensure that practitioners who provide group counselling have the skills to manage (not encourage) : - group discussions -group tasks that promote interaction, bonding and learning - mutual support within the group In other words it is easy to **encourage** people to talk in a group discussion, but the real skill is in **managing** that discussion so it achieves the desired objectives and contributes constructively to the behavioural change process. Thus Weight Watchers recommends that that word 'manage' is used here.	Thank you for your suggestion, however the term 'manage' may be interpreted as indicating an expert-led approach rather than person-centred. Changes have been made to the wording of the recommendation.
Weight Watchers UK	Recommendation 17	21	Measuring outcomes – In terms of eating behaviours, dietary intake and physical activity – these are extremely resource intensive to assess. It is a massive undertaking to collect meaningful data (which is accurate and valid). All too often evaluations contain assessments of these behaviours using tools which are feasible – but have little validity. Weight Watchers recommends that some caveat is included here to help researchers stop and think before launching into evaluations which prove costly and beyond the resources at their disposal. It is suggested that NICE PDG link into the work currently being undertaken by PHE in revising the Standard Evaluation Framework for weight management interventions – where the exact same discussions are going on, about collecting and using valid data on behavioural change outcomes in services.	Thank you for your comment. It was decided that this guidance would not provide specific recommendations for a particular behaviour. For this information, please refer to topic specific NICE public health guidance which is able to cover evidence on interventions for a particular behaviour in more detail. The guidance recommends using validated tools and the recommendation on national support now states that 'National organisations that support the monitoring, collection and surveillance of

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				routine data should work together to: determine what routine data health, social care and voluntary organisations should record on health-related behaviours (such as smoking and alcohol)'
Weight Watchers UK	Recommendation 17	22	Second bullet point down – suggest reference is made to the National Obesity Forum's (Now part of Public Health England) Standard Evaluation Framework for obesity interventions which sets out best quality data to collect and this would apply to interventions which employ BCTs.	Thank you for your suggestion but this inclusion was not seen as necessary.
Weight Watchers UK	Recommendation 18		There is a serious need for some form of national view on behaviour change interventions and programmes commissioned by the health system. At present there is no structure or process to monitor level of investment, level of service provision, uptake and outcomes. There is no national view and hence no national level insight into the requirements to drive forward cost effective, better outcomes for the populations who need it.	Thank you. Your suggestion has been reflected in the re-drafting of the recommendation.
Weight Watchers UK	Background	25	Last bullet point – Does commercial companies in this context mean the food and drinks industry? – if so – Weight Watchers suggests this is clarified. If it is reference to providers of services, suggest 'independent service providers'.	One example may be, but is not exclusive to the food and drinks industry.
Weight Watchers UK	Evidence	27	Bullet point 3:11 – Currently the second sentence is not terribly clear – suggest this is reframed	Thank you for your comment, this has been re-worded.
Weight Watchers UK	Training	32	Point 3.37. Weight Watchers suggests that this should read ' The PDG	Thank you. Your

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			discussed the importance of listening and communication skills for the successful delivery of the behaviour change interventions	suggestion has been reflected in the re-drafting of the consideration.
Weight Watchers UK	Glossary	36	Brief intervention – Within this paragraph there is health emphasis on health professional delivery of behavioural change interventions. Indeed the take out message is that they are the only type of practitioner that can effectively deliver brief interventions. However research and evaluation of the Weight Watchers interventions clearly shows that when lay people (i.e. non specialists) are provided with the right training they can effectively deliver behavioural change interventions with sustained outcomes and currant data availability suggests that a proportion of participants in the Weight Watchers programme will sustain these behaviours (Lowe et al 2008).	Thank you. Your suggestion has been reflected in the re-drafting of this glossary item.
Weight Watchers UK	References used in this response		Heshka S et al (2003) Weight Loss with Self-help Compared with a Structured Commercial Program: a Randomized Controlled Trial,Journal of the American Medical Association, 289 (14):1792-1798. Jebb S A et al (2011) Primary Care Referral to a Commercial Provider for Weight Loss Treatment Versus Standard Care: A Randomised Controlled Trial. Lancet. September 7. Jolly K et al (2011) Comparison of Range of Commercial or Primary Care Led Weight Reduction Programmes with Minimal Intervention Control for Weight Loss in Obesity: Lighten Up Randomized Controlled Trial. BMJ, Nov 3;343 Lowe M R et al (2008) Weight-Loss Maintenance 1, 2 and 5 Years after Successful Completion of a Weight-Loss Programme, British Journal of Nutrition, Apr; 99(4) : 925-930.	Thank you. Please note that we are unable to accept or review additional evidence at this stage.

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			Michie S, et al (2011) Refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALO-RE taxonomy. Psychology and Health 28: 1-20.	