# Public Health Guideline

## Behaviour Change (PH6 – second review) - Consultation on the review proposal
## Stakeholder Comments Table

## 23 June 2014 – 7 July 2014

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|---|---|---|---|---|
| **Barnsley Drug and Alcohol Action Team** | General | | The document is structured in a bottom up way which mitigates against strategic/national context being set, against which both community and individual requirements can cascade out of. Time and again commissioners and providers are frustrated by the lack of guidance and leadership and are exhorted to provide best practice examples. This can result in piecemeal and ad hoc delivery which may, or may not, be picked up by researchers. This often depends on the ability of designers and organisations to promote their activities. Providing a "top, down" flow would result in better strategy coordination and sharper delivery. | Thank you for your comments on NICE public health guidance 'Behaviour change: the principles for effective interventions'.<br><br>Please note that this consultation is seeking views on the recommendations to update this guidance contained in the review proposal. Specifically on whether you are in agreement or not with the following (and issues you feel we should be aware of in relation to these recommendations):<br>1) That the principles in PH6 should be reviewed and refreshed for terminology and contextual issues.<br><br>2) That new guidance will be developed to partially update PH6 on |

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|---|---|---|---|---|
| | | | | effective and cost-effective population-level interventions for health-related behaviour change. The approach will be guided by the Rose principle; i.e. there will be a focus on activities and interventions which reduce the risk levels in the population as a whole, shifting the whole health gradient in the direction of health improvement and being mindful of the impact on the overall inequalities slope of the gradient. This will include a review of the principle in PH6 about 'selecting interventions and programmes aimed at populations' to determine whether it still stands or requires re-drafting.<br><br>. |
| **Barnsley Drug and Alcohol** | 2.25 Planning | | A greater emphasis on co-production would be welcome, which enables | Thank you for your |

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|---|---|---|---|---|
| **Action Team** | and Design Pg 15 | | individuals to help each other as well as add value to local organisations and systems thereby increasing wellbeing. | comment. When the guidance is updated, the Public Health Advisory Group who develop the guidance will consider the available evidence on this. |
| **Barnsley Drug and Alcohol Action Team** | 2.31 Delivery Pg. 16 | | But population-level interventions are generational in their effect, requiring coordinated strategic and national sign-up. | Thank you for your comment. This level of detail may be considered at the update guidance development stage. The current consultation is about whether or not the guidance requires updating. |
| **Barnsley Drug and Alcohol Action Team** | Planning, Principle 1- Pg. 19 | | Should become Principle 2 as planning interventions and programmes works better once the social context is understood | Thank you for your comment. However, the current consultation is on the paper which sets out the case for updating part of the guidance – in terms of changes to evidence and practice – and not the original guidance itself. The issue you raise may be considered as and when the guidance undergoes an update. |

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|---|---|---|---|---|
| | | | | |
| **Barnsley Drug and Alcohol Action Team** | Planning Principle 1 – Pg. 19 | | Recommended action should include bullet points around:<br>• Allocation, use and accounting of partnership resources to achieve holistic results;<br>• Identification of training and support requirements to enhance delivery and outcomes. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. This level of detail may be considered at the update guidance development stage in relation to population-level interventions. |
| **Barnsley Drug and Alcohol Action Team** | Planning Principle 2 – Pg. 20 | | Should become Principle 1 | Thank you for your comment: The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. The issue you raised may be considered as part of the process of updating the principles in PH6 in terms of terminology and contextual issues. |
| **Barnsley Drug and Alcohol Action Team** | Planning Principle 2 – Pg. | | Recommended action: more context should be offered around the second bullet point which asks to "consider in detail the social and environmental | Thank you for your comment. The current |

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|---|---|---|---|---|
| | 21 | | context …" This seems to be similar to the first bullet point. | consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. The issue you raise may be considered as part of the process of updating the principles in PH6 in terms of terminology and contextual issues. |
| **Barnsley Drug and Alcohol Action Team** | Planning Principle 3 – Pg. 21 | | I felt there was no understanding of the need to educate the public, especially if they are required to take a bigger role in planning, developing and participating in delivery. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. This level of detail may be considered at the update guidance development stage in relation to population-level interventions, depending upon the available evidence. |
| **Barnsley Drug and Alcohol Action Team** | Delivery Pg. 22 – 24 General | | The structure of this part echoes my concerns outlined under general comments above. Population level interventions and programmes that deliver policies in particular should come before everything else. That way, at each subsequent, devolved population level, regional and local developers and | Thank you for your comment. The current consultation is on the paper that sets out the |

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|---|---|---|---|---|
| | | | commissioners can pick from a suite of policies, interventions and programmes that are research backed and provide a consistent approach across the nation. The history and success of the National Treatment Agency in providing national context and shaping delivery vindicates a change in order in this case. People will have more confidence to deliver programmes if they know and understand they fit into a wider national context of health progression. | case for a partial update of the guidance, and not on the guidance itself. This level of detail may be considered at the update guidance development stage in relation to population-level interventions. |
| **Barnsley Drug and Alcohol Action Team** | Evaluation – general | | Research is great, what is the vehicle for disseminating any findings to assist at a community, regional and national level? | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. However, further detail on the evaluation of behaviour change techniques used with individuals is provided in PH49 'Behaviour change: individual approaches' and the resources sections for PH6 and PH49. |
| **Centre for Outcomes Research and Effectiveness, and UCL Centre for Behaviour Change** | General | | 1. There is substantially more evidence to draw on than was the case in 2007, both in terms of more sophisticated and informative trials, but also in terms of longitudinal observations datasets that are producing invaluable real-world and policy-relevant findings, for example, the UK's Smoking Toolkit | Thank you for your comments, which are helpful in understanding the current context of |

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|---|---|---|---|---|
| | | | Study<br>2. We now have more unifying frameworks within which we can evaluate and make sense of disparate data across many domains. One that is being used quite widely across the UK Government is the Behaviour Change Wheel – this allows both 'retrofitting' of current policies to identify what they consist of, and what they do not, and systematically identifying evidence for the effectiveness of seven policy categories and nine intervention functions according to target behaviours. However, the experience of the 2014 individual level update demonstrated that reviews are likely to be much more productive if they search for evidence according to intervention function/policy category and then assess in which domains the evidence lies, rather than search according to specific behaviours.<br>3. Over the last decade there has been greater interdisciplinary working in relation to behaviour change suggesting that both theory and evidence are likely to be richer than was the case in 2007 and that a well selected programme development group could contribute cross-silo interdisciplinary thinking about the evidence reviewed.<br>4. There has also been a sharp increase amongst policy makers in behaviour change as evidenced by the Behavioural Insights teams in the Cabinet Office, Department of Health and Public Health England; there has also been an enthusiasm for generating and applying evidence about behaviour change, as evidenced by the increasing seeking of expert advice and support from researchers and other 'knowledge brokers'. | behaviour change interventions and practices. |
| **Chartered Institution of Highways and Transportation** | General | | The NICE guidelines need to better account for the opportunity that transport and planning policy provide to facilitate greater physical activity. The guidelines contain limited references to sidewalks (footways in the UK) and bike lanes – (cycle lanes in the UK), however there should be a greater focus on these areas as infrastructure provision that promotes active travel can play a major role in improved health of people.<br>Promoting behavioural change towards active travel helps people achieve | Thank you for your comments on NICE public health guidance 'Behaviour change: the principles for effective interventions'. |

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|---|---|---|---|---|
| | | | their recommended levels of physical activity. Evidence shows that the easiest way for most people to get more exercise is to build it into the daily routine (SUSTRANS 2013). Increased activity through transport – either walking, cycling and/or use of public transport would help meet people's daily activity targets. Influencing peoples' transport choices should be recognised as an integral part of achieving health behavioural change.<br>Changes in transport behaviour will help with more than just physical activity – it will also help improve mental wellbeing. The relationship between transport activity and general health is recognised in broad terms – i.e. access to health care, personal mobility, better accessibility; but there is a need to recognise that there is a wider impact on mental health and wellbeing.<br>Physical activity reduces number of illnesses, both physical and mental.<br>NICE Guidelines need to emphasise that transport is one element that can help improve national physical health and will result in an economic benefit to the country – for example the less people suffering from diabetes and heart problems, the less pressure on health budgets. The case needs to be made that when developing new transport schemes, planning new housing, schools and retail that government (decision makers) and professionals consider health and wellbeing. The Health and Economic Assessment Tool (HEAT) produced by the World Health Organisation helps prove/quantify the economic benefits of improved transport.<br>Access to public transport, walking and cycling increases accessibility to jobs and society as a whole (good for young and old). A transport system should ensure that all sections of the community have opportunities to access jobs and a full range of services – sustainable transport choices can and should contribute to the delivery of wider objectives, such as reducing poverty, improving health and enhancing the quality of places where people live and work. However a full range of travel choices will also help prevent isolation for the elderly as their physical activity levels are reduced. Older people and those in rural communities may be required to drive – whilst not physically | Please note that this consultation is seeking views on the recommendations to update this guidance contained in the review proposal and not on the original guidance itself:Specifically on whether you are in agreement or not with the following (and issues you feel we should be aware of in relation to these recommendations):<br>1) That the principles in PH6 should be reviewed and refreshed for terminology and contextual issues.<br><br>2) That new guidance will be developed to partially update PH6 on effective and cost-effective population-level interventions for health-related behaviour change. The approach |

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|---|---|---|---|---|
| | | | active – removing this choice could affect mental wellbeing.<br>It is important for institutions such as CIHT and NICE to promote direct investment and increased funding in active transport projects, either physical (cycle routes, improved cycle facilities at stations, improved pedestrian facilities) or non-physical e.g. behaviour change programmes like personalised travel planning (Leicestershire 'Choose how you move' – Personal Travel Planning).<br>Cycling is perceived as dangerous especially amongst certain demographics. However research clearly shows that benefits of cycling (associated with physical activity – e.g. reduced risk of diabetes, high blood pressure, heart attack, stroke and cancer) far outweigh the risks of cycling (air pollution and the risk of having an accident). There is a clear role for Government and transport practitioners/organisations to highlight the advantages.<br>Promoting behavioural change towards active travel helps reduce carbon emissions. Transport policy, practice and implementation will help address impacts on the environment by seeking to reduce dependence on non-renewable fuels and reduce emissions.<br>**Transport and Planning Policy should**:<br>- Choose the right place for development,<br>- Give priority to walking, cycling and public transport (however not forgetting all highway users including car drivers).<br>- Increase transport choices<br>- Ensure transport implications of other policy areas (e.g. health and education) are fully considered<br>- Maximise the use of and benefits arising from evolving technologies.<br>CIHT are currently carrying out research looking at the relationship between Transport, Mobility, Health and Wellbeing and expect a final report in the summer. We will draw a number of conclusions about policy, funding, structural and operational changes that will achieve a net benefit in the health and wellbeing of the UK. CIHT will be happy to share our findings with NICE | will be guided by the Rose principle; i.e. there will be a focus on activities and interventions which reduce the risk levels in the population as a whole, shifting the whole health gradient in the direction of health improvement and being mindful of the impact on the overall inequalities slope of the gradient. This will include a review of the principle in PH6 about 'selecting interventions and programmes aimed at populations' to determine whether it still stands or requires re-drafting.<br><br>The issues you raise may be considered at the guidance development stage, depending on the available evidence. However please note |

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|---|---|---|---|---|
| | | | once published.<br><br>Further information:<br>SAMERU project - Examines/researches the difficulties facing elderly road users.<br>TfL Improving the Health of Londoners – Transport Action Plan – Looking at the role that London's transport service has to play in tackling public health challenges.<br>Active travel Wales Act 2013 – Law to make it easier for people to walk and cycle in Wales. | that the principles in PH6 are generic principles, i.e. is not behaviour-specific. There is other public health guidance that is specific to physical activity – for example please see PH8 'Physical activity and the environment', PH41 'Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation'. |
| **Diabetes UK** | 3 Policy context | | We agree that it is important to translate the evidence into actionable recommendations | Thank you. |
| **Diabetes UK** | 3 Evidence | | We agree that the evidence on changes in pricing or taxes on unhealthy products should be reviewed and recommendations made. We would also like to see the inclusion of any evidence on the effects of subsidies on veg and fruit. | Thank you for your comment and for your suggestion, which has been noted and will inform the guidance development. |
| **Diabetes UK** | 3 Evidence | | We also support the need to review evidence on the effects of digital social networks and communities. | Thank you. |
| **Diabetes UK** | 3 Evidence | | Again – we support the proposed review of the evidence in relation to the modification of the physical environment to encourage physical activity. | Thank you. |
| **Diabetes UK** | 3 Evidence | | We also agree with the need to include new studies evaluating the effectiveness of mass media and social marketing campaigns. | Thank you. |

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|---|---|---|---|---|
| **Diabetes UK** | 3 Evidence | | We would also like to see any evidence on the interaction between mass campaigns and local messaging. | Thank you for your suggestion. The original guidance included recommendations on the need to co-ordinate interventions at different levels, for example population- and community. We will ensure that this is included in the updated guidance. |
| **Diabetes UK** | 7 Recommendation | | We fully support that the approach should be guided by the Rose principle and that the impact on health inequalities must be addressed in the guidance. | Thank you. |
| **Department of Health** | General | | **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.** | Thank you. |
| **Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.** | General | | We agree that the principles in PH6, while useful, should be reviewed and updated to reflect the current structure of public health. | Thank you. |
| **Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.** | General | | We agree that more detailed guidance, using the new evidence available on population based interventions, should be developed. | Thank you. |
| **Dietitians in Obesity** | Section 3: | | We welcome the emphasis on evaluation of policy interventions and would | Thank you for your |

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|---|---|---|---|---|
| **Management UK (domUK), a specialist group of the British Dietetic Association.** | Evidence: policy p4 | | welcome guidance on a number of different evaluation options, including but not limited to the Behaviour Change Wheel. | comment. Your suggestion not to limit evaluation to defining interventions according to the behaviour change wheel categorisations has been noted. |
| **Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.** | Section 3: Evidence P6 | | We welcome the intention to include evidence on mass media and social marketing campaigns. | Thank you. |
| **Heart of Mersey – part of the Health Equalities Group** | 6 Conclusion | | The Health Equalities Group recommends that the PH6 guidance should be reviewed because of the new evidence summarised in section 6 and the changing contextual issues. | Thank you. |
| **Heart of Mersey – part of the Health Equalities Group** | 7. Recommendation | | The Health Equalities Group strongly recommends that there should be an explicit commitment to focus on population-based interventions that reduce health inequalities. | Thank you for your comment. All guidance is developed to ensure it promotes equality and does not discriminate against any groups. Evidence, if available, for different groups would be reviewed as part of guidance development. We also carry out an equity assessment on all stages of guidance development, to ensure that equity issues are |

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|---|---|---|---|---|
| | | | | considered and taken into account. This assessment is published alongside the final guidance. |
| **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** | | | Lundbeck welcomes and supports the review proposal on the update of PH6 'Behaviour change' and recommends that the review of the principle included within the guidance on 'selecting interventions and programmes aimed at populations' incorporates alcohol as a key risk factor for population-level ill-health.<br><br>There is a strong body of evidence demonstrating the harmful health impacts of excessive alcohol consumption. Harmful alcohol use is listed alongside tobacco use as one of the two highest risk factors for early death and disability in the UK in Volume One of the Chief Medical Officer's Annual Report[1] (as according to The WHO national burden of disease toolkit).<br><br>Considering the wide-reaching burden attributable to alcohol-related harm - costing society an estimated £21 billion[2] and the NHS in England £3.5 billion[3] every year - there is a clear and well-evidenced need for addressing alcohol-related harms. Population-level information and education orientated programmes have been shown to have a positive contribution in helping to increase attention and acceptance of alcohol on the political and public agendas.[4]<br><br>It is therefore important that the update to PH6 clarifies where responsibility | Thank you. Alcohol was one of the risk factors looked at in the original behaviour change guidance and as such evidence on population level interventions are likely to be part of the update.<br><br>Thank you for your comment concerning the need for integration of individual-level and population-level interventions. PH49 does highlight that 'Sustained behaviour change is most likely to occur when a combination of individual, community |

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|---|---|---|---|---|
| | | | lies in the new public health commissioning environment for the provision of population-wide interventions targeted at reducing alcohol-related harms, both at a national and a local level.<br><br>While Lundbeck acknowledges that the provision of individual-level screening and brief interventions for alcohol are outside the scope of this review - taking into account the recently published guidance on 'behaviour change: individual approaches' - it is important that clarity is provided in terms of where PH6 sits in relation to PH49. Clear lines of accountability must be set out within the guidance to ensure that population-level behaviour change programmes are effectively integrated with follow-up individual-level interventions, such as those to address harmful levels of alcohol consumption. | and population-level interventions are used.' The relationship between PH6 and PH49 is perhaps best illustrated in the pathway for behaviour change. The original guidance included recommendations on the need to co-ordinate interventions at different levels, for example population- and community. We will ensure that this is included in the updated guidance. |
| **Macmillan Cancer Support** | General | | Links to other relevant guidance such as PH49 needs to be updated | Thank you for your comment. The link between PH6 and PH49 is made on the NICE website and the behaviour change pathway. We do not provide updated links within guidance documents to guidance published at a later date than the original |

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| | | | | guidance.<br><br>Please note that this consultation is seeking views on the recommendations to update this guidance contained in the review proposal. Specifically on whether you are in agreement or not with the following (and issues you feel we should be aware of in relation to these recommendations):<br>1) That the principles in PH6 should be reviewed and refreshed for terminology and contextual issues.<br><br>2) That new guidance will be developed to partially update PH6 on effective and cost-effective population-level interventions for health-related behaviour change. The approach |

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| | | | | will be guided by the Rose principle; i.e. there will be a focus on activities and interventions which reduce the risk levels in the population as a whole, shifting the whole health gradient in the direction of health improvement and being mindful of the impact on the overall inequalities slope of the gradient. This will include a review of the principle in PH6 about 'selecting interventions and programmes aimed at populations' to determine whether it still stands or requires re-drafting. |
| **Macmillan Cancer Support** | 1 | | Use of the term exercise; we would recommend that 'physical activity' is used preferentially. | Thank you for your comment. Please see above concerning detailed comments on the content of PH6. |
| **Macmillan Cancer Support** | 1 | | Where the document refers to 'a health system that may reinforce social and | Thank you for your |

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| | | | economic inequalities', we question whether this is still in context considering the health and social care act 2012 and the redesign of public health. | comment. This will be considered as part of the process of updating PH6 in terms of terminology and contextual issues. |
| **Macmillan Cancer Support** | 2.3 | | Explicit, formal evidence (at the level searched) was scarce - is this still the case? | Please see response above. |
| **Macmillan Cancer Support** | 2.5 | | The PDG concluded that the evidence did not support any particular model - is this still the case? | Please see response above. |
| **Macmillan Cancer Support** | 2.7 | | Does this information need updating? | Please see response above. |
| **Macmillan Cancer Support** | 2.8 | | Does this information need updating? | Please see response above. |
| **Macmillan Cancer Support** | 2.29 | | No mention of guideline production, regulation, environmental and social planning all of which have been shown to have an impact on population level behaviour change. We would suggest that these are included | Thank you for your comment. These have been considered as part of the review proposal for updating the principle on population level interventions – the focus of this review proposal consultation. |
| **Macmillan Cancer Support** | 4 | | Information is out of date | Thank you for your comment. This will be dealt with when PH6 is refreshed for terminology and context. |
| **Macmillan Cancer Support** | Appendix B | | In key questions, there are no questions about the long term change in | Thank you for your |

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|---|---|---|---|---|
| | | | behaviour. We would suggest that a question is included to see whether the intervention can sustain behaviour change for a minimum of 12 months. | comment – please see response above. |
| **Macmillan Cancer Support** | Appendix B | | We would suggest that it includes reviews of interventions to reduce alcohol intake | Thank you for your comment – please see response above. |
| **Mind** | General | | Mind and Rethink Mental Illness have been co-leading an intervention called Time to Change to change public behaviour in relation to mental health discrimination since 2007. Time to Change aims to improve the way the public treat the one in four people who will experience a mental health problem in any year, using a combination of social marketing and community-based 'social contact' activity.<br><br>Time to Change has evidenced an impact on public behaviour at a population level. This is the first campaign of its kind internationally to demonstrate behaviour, as well as attitude change in relation to mental health stigma and discrimination. Several other campaigns around the world have since used evidence from Time to Change to develop behaviour change interventions in this area including in the USA, Canada, Sweden, Norway and Denmark.<br><br>Time to Change is evaluated by the Institute of Psychiatry, King's College London who have published several studies documenting Time to Change's impact on behaviour change including a special supplement in the British Journal of Psychiatry in 2012; in which one study showed an 11.5% reduction in average levels of reported discrimination (ie people behaving differently towards the sample of people with mental health problems). Being aware of the Time to Change campaign and having social contact with someone with a mental health problem were two of the most significant factors affecting improved attitudes and intended behaviour amongst the public target audience for the Time to Change campaign. The supplement is available open access here: http://bjp.rcpsych.org/content/202/s55.toc | Thank you for the information on the Time to Change intervention. Following the final decision on updating the guidance, it will go into NICE Centre for Public Health schedules for development. When guidance development begins we may issue a call for evidence to all stakeholders and we would encourage you to re-submit this information (and any other relevant evidence) at that point so that it may be considered for inclusion in evidence reviews. |

| Stakeholder Organisation | Section Number | Page Number | Comments<br>Please insert each new comment in a new row. | Response<br>Please respond to each comment |
|---|---|---|---|---|
| | | | Given this new evidence, we would support an update to the guidance as proposed and would offer evidence and case studies from Time to Change for inclusion. | |
| **Public Health England (PHE)** | General | | Public Health England (PHE) support the proposal to review the guidance. The guidance should clarify what is considered to be individual-level behaviour change and what is community or population behaviour-change. For example smoking cessation services are traditionally delivered face-to-face to individuals or small groups but these are community or national programmes with standardised content of behaviour change techniques (BCTs). Similar combinations of BCTs are now being delivered digitally. Therefore, the role of the medium will be important to consider. | Thank you for your support of the update proposal.<br>The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. We will take this point into account as and when the guidance is updated – however, PH6 does include definitions of the different levels of intervention, as does PH49 and the local government briefing on behaviour change which was published last year.<br><br>We note that mode of delivery of interventions should be considered when evidence is reviewed. |

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| **Public Health England (PHE)** | General | | Building on the above, please consider evidence for the targeting/tailoring and/or segmentation of these behaviour-change interventions for maximising effectiveness in different sub-populations. | Thank you for your comment. All guidance is developed to ensure it promotes equality and does not discriminate against any groups. Evidence if available for different socio-economic, ethnic and other groups is always reviewed as part of guidance development, and the recommendations will reflect the available evidence. |
| **Public Health England (PHE)** | General | | The original guidance was for those helping people change their health-related knowledge, attitudes and behaviour. The revised guidance should focus on behaviour only unless there is clear evidence that the change in knowledge and attitudes concerned results in behaviour change. | Thank you for your comment. The original guidance was developed in response to a specific referral from the Department of Health which included these terms, and the current consultation focuses on the proposals set out in the consultation paper to update this specific guidance. Since publication of PH6 a considerable amount |

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| | | | | work has been published around 'choice architecture' or 'nudges' – examples of interventions that focus on behavjour alone, and these would be included in the current update proposal. Whilst changes in knowledge and attitudes are not always linked to behaviour, they can be important aspects of a multi-factor approach and any evidence reviews undertaken as the updated guidance is developed will include a focus on behavioural outcomes. |
| **Public Health England (PHE)** | General | | We need to identify which interventions and behaviour change techniques are effective for which public health issues. Therefore, this should refer to Michie's Behaviour Change Taxonomy where possible to facilitate standardisation and translation of evidence. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Decisions concerning taxonomy used will be |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | made as part of any resulting guidance development process, and stakeholders will be able to comment on this during scope consultation. |
| **Public Health England (PHE)** | General | | A number of the comments here relate to what might be referred to as the 'intensity' and 'scope' of the behaviour change interventions. The 'intensity' relating to the Nuffield ladder of bioethics, the 'scope' relating to the Dahlgren and Whitehead model of social/wider determinants of health. The question is whether there is evidence of population behaviour change having been delivered across both of those spectra. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. |
| **Public Health England (PHE)** | General | | There should be discussion of the mandate for behaviour change by others – to what extent are interventions helping people to make healthier decisions or making those decisions for them – and what are the implications? | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. |
| **Public Health England (PHE)** | General | | The guidance needs to take account of the major changes to the Health and Social Care system that have taken place since the last update. These include the transfer of public health to local authorities and the increasing pressure on budgets with the associated need to demonstrate return on investment. | Thank you for your comment. This is acknowledged in the review proposal consultation paper. |
| **Public Health England (PHE)** | General | | There needs to be a focus on structural issues that 'drive' behaviours: please consider a section that deals with transport and housing. For example: regeneration; city / town centre redevelopment; transport schemes (both urban | The current consultation is on the paper that sets out the case for a partial |

| Stakeholder Organisation | Section Number | Page Number | Comments<br>Please insert each new comment in a new row. | Response<br>Please respond to each comment |
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| | | | and rural) including those that are about vehicles and how we use evidence to ensure we're securing health and wellbeing benefits there as well as getting people to move about more (active transport). | update of the guidance, and not on the guidance itself. This level of detail may be considered at the guidance development stage. However please note that the principles in PH6 are generic principles, i.e. is not behaviour-specific. There is other public health guidance that is specific to physical activity – for example please see PH8 'Physical activity and the environment', PH41 'Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation'. |
| **Public Health England (PHE)** | General | | The revised guidance should cover translation issues, drawing as necessary on the newer sciences including behavioural, implementation and social science. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Our recommendations |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | will depend upon the available evidence. |
| **Public Health England (PHE)** | General | | It is essential that any guidance on behavioural change acknowledges that many people in deprived communities face genuine difficulty in changing behaviour (e.g. it is difficult to get out to walk or meet people if you don't feel safe in the neighbourhood in which you live). | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. All guidance is developed to ensure it promotes equality and does not discriminate against any groups. Evidence, if available, for different groups would be reviewed as part of guidance development. |
| **Public Health England (PHE)** | General | | The review should compare the effect on inequalities of interventions focused on reflective vs automatic processes. There are indications that interventions focused on reflective processes benefit the health literate disproportionately and increase health inequalities, whereas interventions focused on automatic processes may benefit all similarly. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itsel, and a 'published guidance review' is not a formal evidence review. All guidance is developed to ensure it |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | promotes equality and does not discriminate against any groups. Evidence, if available, for different groups would be reviewed as part of guidance development. |
| **Public Health England (PHE)** | Policy Context | | Guidance should highlight opportunities for health behaviour change in local authorities including environmental planning, building design, licensing. Providing examples of evidence based tools such as – Healthy Urban Planning Checklist & Toolkit, Active Design Principles. Considering Choice Architecture. | Thank you. This level of detail may be considered at the guidance development stage. |
| **Public Health England (PHE)** | Policy Context | | Guidance needs to indicate where action needs to be taken in the new system and at what level including recommended actions for Public Health England, NHS England, Health Education England, Clinical Commissioning Groups, Local Authorities, Health and Wellbeing Boards, transport planners, designers and architects. | Thank you for your comment – please see above This information would be considered at guidance development stages (scope and draft scope consultation) |
| **Public Health England (PHE)** | Policy Context | | Guidance needs to be translatable to local authorities, NHS organisation, primary & secondary care, providers and commissioners of services, voluntary and third sector. It must consider opportunities to embed behavioural science in commissioning processes and all services provided. | Thank you for your comment. Local government briefings of guidance are developed to support this. |
| **Public Health England (PHE)** | General | | The role of choice architecture needs to be highlighted and recommendations for effective interventions including signage, point of decision making prompts, layout of buildings etc | Thank you for your comment. Choice architecture interventions have been highlighted as an area that would be |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | included in the proposed update in the consultation paper. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. |
| **Public Health England (PHE)** | Evidence | | Guidance should make recommendations around the application of behavioural insights making reference to the use of models and theories from behavioural economics, health and social psychology. Clarifying the nature of the different approaches will be useful to practitioners. | The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Any recommendations made in updated guidance would be dependent on the available evidence. |
| **Public Health England (PHE)** | Evidence | | Guidance should have an increased focus on tools for effective intervention design, implementation, evaluation and translation. Guidance should make recommendations about new frameworks to design behavioural interventions such as MINDSPACE, EAST, BCW. | The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Once a decision on whether to update has been published, the update will go into development and a scope that includes |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence. |
| **Public Health England (PHE)** | Policy Context | | Guidance should make reference to the responsibility deal and sustainability agendas. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Once a decision on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence |
| **Public Health England (PHE)** | Evidence | | Guidance should make recommendations for large employers, commercial | Thank you for your |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | organisations. | comment. The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Once a decision on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence |
| **Public Health England (PHE)** | Evidence | | Guidance should provide recommendations on the use of mobile technology and apps for behaviour change. | Digital technologies are highlighted in the proposal as areas that could be included in an update. |
| **Public Health England (PHE)** | Evidence | | Guidance should advocate embedding behavioural science training within core professional training. | Thank you for your comment. The current consultation is on the paper that sets out the case for a partial update |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | of the guidance, and not on the guidance itself. Once a decision on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence |
| **Public Health England (PHE)** | Policy Context | | Guidance should take into consideration the every contact counts agenda – widening the remit of this guidance to non-traditional health professionals. | Thank you for your comment. Every contact counts relates to individual-level interventions which were covered in PH49 'Behaviour change: individual approaches' |
| **Public Health England (PHE)** | Evidence | | Guidance should be updated to reflect new research needs. | The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself. Once a decision |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence |
| **Public Health England (PHE)** | Section 5 p6 | | Although the guidance is at a population level it would be helpful if NICE could consider in this review the impact of population level interventions on different sub-groups within the population (e.g. the focus on smoking cessation advertising on motivation to quit based on children has been highlighted as alienating lesbian, gay, bisexual and trans individuals; taxation of food and drink components raises questions about impact on those living in poverty; some very simple gaps in recognition can mean that improving the built environment for physical activity can disadvantage those who are disabled. It is important that the review considers the impact on inequalities and minority communities in more detail as these are often forgotten in population level interventions. | Thank you for your comment. All guidance is developed to ensure it promotes equality and does not discriminate against any groups. Evidence, if available, for different groups would be reviewed as part of guidance development. |
| **Public Health England (PHE)** | General | | If possible, could Excess Winter Deaths and Fuel Poverty be considered areas for comment in the review? Epecially given the references to Excess Winter Deaths in the Health and Wellbeing Framework (to be published shortly) and NICE's new guideline on Excess Winter Deaths and morbidity and the health risks associated with cold homes? | Thank you for this request. However, excess winter death and fuel poverty are outside the remit of the original guidance and would |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | therefore not be included in this update. There is NICE public health guidance in development and due for publication at the end of the year on excess winter deaths |
| **Public Health England (PHE)** | General | | Please note the sustainability of interventions where possible. | Thank you – this information would be considered as part of the guidance development process. |
| **Public Health England (PHE)** | General | | Should we aim to increase personal/social responsibility through externally imposed interventions where possible to maximise sustainability and wider impact? | The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself – please see the review proposal.. Once a decision on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will |

| Stakeholder Organisation | Section Number | Page Number | Comments<br>Please insert each new comment in a new row. | Response<br>Please respond to each comment |
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| | | | | depend upon the available evidence |
| **Public Health England (PHE)** | General | | Please highlight the unintended consequences where possible. | Thank you – this information would be considered as part of the guidance development process. |
| **Public Health England (PHE)** | General | | Is there evidence for addressing multiple behaviours simultaneously (rather than in sequence)? This may be because of the concept of improved outcomes using a holistic approach. However, a population approach to a single behaviour may better complement person-centred holistic approaches? | The current consultation is on the paper that sets out the case for a partial update of the guidance, and not on the guidance itself – please see the review proposal. Once a decision on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence |
| **Public Health England (PHE)** | General | | Do population level behaviour change interventions lead to preference changes? | The current consultation is on the paper that sets out the case for a partial |

| Stakeholder Organisation | Section Number | Page Number | Comments<br>Please insert each new comment in a new row. | Response<br>Please respond to each comment |
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| | | | | update of the guidance, and not on the guidance itself – please see the review proposal. Once a decision on whether to update has been published, the update will go into development and a scope that includes detail on what the guidance will and will not cover will be sent for consultation with stakeholders. Final recommendations will depend upon the available evidence |
| **Public Health England (PHE)** | General | | Does community involvement maximise or limit the effectiveness for behaviours driven largely through the automatic system? | We can only respond to comments on the update review proposal. NICE guidance identifies, collates and interprets existing evidence – we do not undertake primary research. We do identify gaps in the available evidence in all of our guidance, and we include a section on recommendations for |

| Stakeholder Organisation | Section Number | Page Number | Comments Please insert each new comment in a new row. | Response Please respond to each comment |
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| | | | | research. |
| **Public Health Warwickshire** | 3 | | It is noted in the review proposal that the new council based context needs to be considered as an audience for the guidelines for public health on behaviour change. In addition, the importance of translating the evidence into actionable recommendations is noted. With both PH6, PH49 and with the possible forthcoming update, a major issue for public health (wherever it sits) is the level of capacity, resource, skill and knowledge to implement such recommendations. In Warwickshire, we have for the last 3 years employed two health psychologists based at a local university and seconded part-time to our department to support embedding of behaviour change evidence, development of interventions and evaluation of interventions into the work that we do. This is a model with huge potential nationally, and was commented on as such by Duncan Selbie in a recent visit to Warwickshire. We would urge the PDG to consider including reference to this amongst its recommendations. | Thank you for this information. A call for evidence is put out when guidance is being developed and we suggest that you provide any evidence on the effectiveness of the approach taken in Warwickshire at that stage. |
| **Public Health Warwickshire** | 3 | | Although the DH and PHE may have teams involved in examining the application of behaviour change techniques, there has been limited infiltration nationally within local public health departments. We refer you to the comment above regarding our own activities in relation to this. | Thank you. |
| **Public Health Warwickshire** | 3 | | Although behaviour change guidance at an individual level has been considered in the PH49 update, it is still important to consider the relevance of behaviour change techniques (and most up-to-date 93 item taxonomy not just intervention functions and policy categories) in relation to population level interventions. These can be particularly relevant for the development of interventions that make use of new technologies such as websites and apps that are becoming increasingly popular as tools for health promotion and illness prevention, and that often target or influence whole populations. NB Note that choice architecture is classified within the 93 item BCT taxonomy as changing the environment. | Thank you for your comment – we appreciate input from local and regional public health teams, and this information provides us with useful context to the update proposal. |
| **The Royal College of Midwives** | General | | The Royal College of Midwives agree with the recommendation in this | Thank you. |

# Public Health Guideline

## Behaviour Change (PH6 – second review) - Consultation on the review proposal
## Stakeholder Comments Table

## 23 June 2014 – 7 July 2014

***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***

| Stakeholder Organisation | Section Number | Page Number | Comments<br>Please insert each new comment in a new row. | Response<br>Please respond to each comment |
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| **(RCM)** | | | proposal to review the evidence and update this guidance. | |
| **The Royal College of Nursing** | General | | This is to inform you that there are no comments to submit on behalf of the Royal College of Nursing to inform on the above review proposal.<br><br>Thank you for the opportunity to review this proposal. | Thank you. |
| **Royal College of Paediatrics and Child Health** | General | | BACD officers agree that there is sufficient new evidence, particularly regarding the marked increase in social media use, to justify an update to this Public Health guidance on Behaviour Change interventions. | Thank you. |