NICE PUBLIC HEALTH PROGRAMME GUIDANCE
BEHAVIOUR CHANGE

5th meeting of the Programme Development Group
11th and 12th December 2006, MWB Exchange, London.

MINUTES

Attendees on 11th December:	*Members:* Charles Abraham, Vimla Dodd, Christine Godfrey, Karen Jochelson, Terence Lewis, Miranda Mugford, Roisin Pill, Wendy Stainton Rogers, Stephen Sutton, Martin White, David Woodhead, Ann Williams. *Co-opted members:* Ray Pawson, Robert West *NICE* Chris Carmona, Alastair Fischer, Jane Huntley, Mike Kelly, Lesley Owen, Catherine Swann, Emma Stewart *NICE observers* None *Review Team:* Julia Fox-Rushby, Gethyn Griffiths, Martin Buxton (Brunel University) A stenographer was present.
Apologies:	Mildred Blaxter, Vicky Cattell, Miranda Lewis, Jennie Popay
Audience:	None

Agenda Item	**Minutes**	**Action:**
Welcome and introductions	Stephen Sutton agreed to chair the group in Mildred Baxter's absence. He welcomed the group.	
1. Declaration of interest (Stephen Sutton)	A roundtable of previously undeclared declarations took place: There were no new declarations	

2.

Minutes of last meeting.

(Stephen Sutton)

Relevant papers: BC4- MINUTES

The minutes were approved as a true and accurate record.

Matters arising from the minutes

- Web-board update: The 'chat' function on the web-board has been abandoned, however the message board function is working well and all the NICE documents and papers from meetings have been posted on there.
- Martin White has circulated a paper and this will also be put on the web-board. Terry Lewis asked if it could be e-mailed to him separately. **NICE**
- Relevant evidence briefings are also on the web-board.
- A link to the Nuffield Council for Bioethics site is on the web-board.
- As requested, NICE resent the web-board instructions to PDG members.

Relevant papers: BC5-2

3, 4, 4a. Review of evidence: The cost effectiveness of behaviour change interventions designed to reduce coronary heart disease.

The Brunel team presented their review on cost effectiveness and the committee were invited to ask questions.

The following points were raised and noted:-

Question and Answer Session

- The need to be aware of context when looking at cost-effectiveness data
- The selection criteria for the review were focussed on CHD therefore the review only looked at health gains related to CHD rather than the broader field of behaviour change.
- There were no consistent patterns which would allow one to make overall/generic statements about behaviour change. The committee need to be clear that cost-effectiveness is a ratio rather than an absolute value.
- The review did not consider the evidence on economic decision making. People are not passive recipients of interventions.
- The review should be based primarily on evidence of effectiveness.
- The committee were interested in the possibility that they may be able to say something about when population approaches are more effective than individual ones.
- It must be remembered that some phenomena, such as blood pressure and alcohol use, exhibit a J-shaped relationship with health outcome which further complicates the picture.
- It is almost impossible to break the data down by ethnicity or SES
- There is currently no funding attached to CPHE guidance.
- Newcastle University and the University of East Anglia are currently working on an NHS R&D project looking at the social value of a QALY. This study will report next year.

The Brunel team were invited to continue with their modelling study as planned.

The NICE team were asked to extract and collate the evidence statements from economics report **NICE**

5. Typology of interventions

Relevant papers: PETeR: a universal model for health interventions - tabled

MW/NICE

(Martin White)

Martin White presented a paper on the typology of interventions to the group. The paper will be available on the web-board.

The following points were noted during the ensuing discussion

- Education may be better renamed 'communication' to allow for support-type interventions
- The model could usefully have more detail at the intervention level
- These are not elements of programme theories, but rather are classified as 'actions' or 'things we do'
- The idea of typology is a useful one which should be driven forward.

6. Round robin on recommendations

Relevant papers: Round-robin comments from Members on Recommendations - tabled

(Mike Kelly pp. Mildred Blaxter)

Mike Kelly thanked Mildred and the group for their input to the paper. He noted that the committee had reached the limits of what the current CPHE methodology can achieve.

MK suggested that the way forward would be for small sub-groups of the committee to coalesce around the recommendations suggested in Mildred Blaxters feedback (points a – e)
The committee felt they may also be able to make a recommendation f) about the effectiveness of health professionals giving advice.

Other points arising in this session:-

- The synopsis document is due to be published for consultation on 27th December
- A review of psychological models of behaviour change would be a useful suggestion for a future topic **NICE**
- Some recommendations could also probably be made regarding specific models. Self-regulatory behaviours looks like a promising field, for example.
- An SDO briefing paper on 'Choice' was highlighted to the committee.
- The group were keen to feed back their experiences of testing the NICE model to destruction.
- Exceeding the NICE model gave the committee a license to be creative, but recommendations still need to remain scientific and auditable.
- To do this the committee would need to define some clear guidelines about what constitutes evidence. For example, does this include expert opinion based on the reviews? **All**
- Would it be reasonable to make recommendations where there is no extant evidence to the contrary? **All**

The committee asked NICE to produce a short sheet of guidance on how to continue. **NICE**

7. **Close** Stephen Sutton	Professor Sutton closed the meeting for the day. The committee would re-convene at 9:30 on Tuesday 12th December in the same venue.

Attendees on 12th December:	*Members* Charles Abraham, Vimla Dodd, Christine Godfrey, Karen Jochelson, Terence Lewis, Miranda Mugford, Roisin Pill, Wendy Stainton Rogers, Stephen Sutton, Martin White, *Co-opted members:* Ray Pawson, Robert West *NICE* Chris Carmona, Alastair Fischer, Jane Huntley, Lesley Owen, Clare Wohlgemuth *NICE observers* None *Review Team:* Gerard Hastings and Laura McDermott (University of Stirling) A stenographer was present.
Apologies:	Mildred Blaxter, Vicky Cattell, Mike Kelly, Catherine Swann, Ann Williams, David Woodhead
Audience:	None

Agenda Item	**Minutes**	**Action:**
1. **Welcome and introductions**	Christine Godfrey agreed to chair the group in Mildred Blaxters absence. She welcomed the group.	
2. **Expert witness presentation:** **Cost effectiveness to society of preventable ill health.** (Dr Graham Lister)	***Relevant papers: BC5-4*** Dr Graham Lister presented 'Cost effectiveness to society of preventable ill health' commissioned by the National Social Marketing Centre. NICE to circulate Dr. Lister's presentation. The following points were raised during the ensuing discussion: • The lack of data on productivity costs in the report was a result of a lack of time to locate such data, not because none exists. The report attempted to pull together what data could be found	**NICE**

that was of reasonable quality within the given time frame.

- Dr. Lister's remarked that a language of wellness needs to be created, it was commented that a language of wellness already exists in the 'commissioning world'.
- The creation and potential benefits of 'Health Direct', a health adviser line, was discussed. The service will be able to provide self-assessments over the phone, it was commented that a lot of people prefer an automated service.
- A lot of behaviour effects social capital, there is perhaps a need for sociologists to find a method of expressing a value for social capital.
- Important to calculate a cost per behaviour change but also to have a wider view of the costs resulting from behaviour change than just cost per QALY.

3. Review of the Evidence: The effectiveness of general interventions, approaches and models at individual, community and population level, that are aimed at changing knowledge, attitudes and behaviours in road safety, environmental behaviour and marketing of public health. Section Three: The Marketing Review.

(Gerard Hastings)

Relevant papers: BC5-5

The following points were noted during the ensuing discussion:

- Important to be consumer orientated – recognising the viewpoint of those whose behaviour you want to change.
- It was acknowledge that branding represents trust with regards to factors such as reassurance of quality which develops between manufacturers and consumer. Reassurance of quality was felt to be particularly important to people on limited budget and this is perhaps why people of lower socio-economic status prefer brands, as it minimises risk.
- Branding public health interventions will be difficult, given the *ad hoc* nature of intervention delivery. Coordination and longevity of interventions is required if branding is to be a possibility.
- The influence of parents on children's behaviour was discussed. With regards to healthy eating McDonalds is viewed by parents as an opportunity to 'treat' their children and at the same time it is cheap and welcoming of children. If behaviour is to be changed, a healthy alternative would need to be provided that met all these requirements. The need to consider why unhealthy foods and drink are so cheap was also considered, with the 1970s CAP being felt to blame for the market being stacked in favour of high fat and high sugar food.
- Branding 'active consumption' such as smoking and exercise will be difficult.
- There is a need to define and defend a brand called 'wellness and health'.
- Commercial marketing techniques could be utilised in the public health arena such as air miles and store cards. This would tie in with life being a process, not an outcome and the need for an ongoing relationship as opposed to one-off transactions. A lot can be learned from the commercial marketing employed by companies such as Weight watchers.
- It is important to promote the enjoyable aspects of health promoting activities, rather than focusing on the negative.
- Changing the behaviour of professionals, such as employees of NICE, PCTs and those in commissioning positions should be considered.
- Social marketing is about changing perception, specific lessons included:
  1. GP advice should be action orientated
  2. Campaigns need to be sustained, with marketing an

ongoing process.

- Scepticism was raised regarding social marketing from an inequalities point of view. It was expressed that some messages are only heard if they come from a certain direction at a certain time. It was also felt that messages from social marketing are not new, existing already in social research.
- It is important to distinguish between subsets within a socioeconomic group.
- Commercial worlds are having iatrogenic effects on community capital.
- Important to treat lower socioeconomic groups as human beings, for example, by treating with respect and not perceiving the behaviours of people of lower SES as feckless or stupid.

NICE to extract learning points/statements from social marketing report. **NICE**

4. Review of the evidence: Open discussion and drafting of recommendations

(Wendy Stainton Rogers pp. Mildred Blaxter)

<u>Working Groups</u>

The following groups were formed, they will work independently outside meetings to come up with draft recommendations or statement: **PDG**

1. Meta-level interventions – will be led by Karen, with Jennie, Terry and Martin. Supported by Catherine Swann

2. Intervention through communication/education – Note from NICE team – we propose to combine this with 3

3. Theoretically driven interventions - will be led by Charles with Stephen (and Wendy?). Supported Lesley Owen

4. Micro-level building on strengths interventions - will be led by Wendy, with Roisin and Vimla. Supported by Chris Carmona

5. **Economics** - will be led by Christine, with Miranda. Supported by Alastair

Each group will consider life stages.

Groups need to have completed this task by end of January. **PDG**

NICE to email PDG members supporting information for compiling draft recommendations, including: **NICE**

- Details of how to write the new behaviour change recommendations taking account of other literature and expert opinion.
- A full list of behaviour change draft recommendations compiled to date, evidence statements and matrix.

5. Drafting recommendations

Jane Huntley announced the procedure to be used to take forward the drafting of recommendations:

Before the next meeting of the PDG and to expedite discussion then, groups within the PDG will be formed to further develop recommendations within a classification system the PDG will devise today.

- A person from the NICE team will be assigned to each group and will advise on process. **NICE**

- Groups do not need to stick rigidly to the evidence found in the evidence base. Members of the groups will have their own expertise and experience to bring to bear on the matters under discussion, and should use that source of knowledge when appropriate. **PDG**

- NICE to send around a list of recommendations in matrix form, and to email addresses of all people in the PDG and evidence-based statements. Recommendations from today's presentations will be included. **NICE**

- It was noted that with respect to the kind of evidence discussed at this meeting, economic modelling is not of the same style or nature as RCT and other similar evidence, but in its own way may constitute good evidence. It will be used in this project as exemplars only.

- Concern was expressed that lay input is not being valued in the behaviour change PDG committee.

6. Evidence on the effect of interventions to change behaviour on inequalities in health.

The following points were made in reference to evidence on the effect of interventions to change behaviour on inequalities in health:

- Martin White has written a chapter, not a systematic review, on how inequalities might widen as a result of health interventions, even if the worse-off are decreasing in absolute numbers. This document can be found on the website. It was acknowledged that socioeconomic gradients may shift for many reasons and vary for different interventions, as well as for different components and stages of interventions. For example, the "Back to sleep" intervention to reduce SIDS made a huge difference to cot death but widened relative inequalities.

- The nature of the intervention as well as its implementation is felt to be important. Empirical evidence on *how* each intervention works and *why*, is important. Summary points from different sources are also needed.

- It is not always the case that general improvements in an aspect of health care widen inequalities. There is a higher than average proportion of disadvantaged smokers in NHS smoking cessation schemes. In respect of inequalities in smoking cessation, education, poverty and income support all have an effect

- Increases in inequalities can be traced partly to the nature of the intervention and partly to the way it has been implemented

- Interventions might also have adverse consequences, and a trade-off between reduction in inequality against increased risk must be undertaken. Further, some interventions are more likely than others to reduce/increase inequality: *compulsion* is more likely to reduce inequalities and *voluntary* schemes to widen them

- Additionally, educational interventions are likely to increase inequalities, PCTs need to be aware of this and input more greatly at the lowest educational level.

- The problems of a person from a lower social-economic standing

might not be recognised by those delivering an intervention. A change in the delivery mechanism might be required for them, particularly in the case of complex interventions.

- NHS commissioners need to know if there are non-intended consequences to interventions, or where they run contrary to inequality objectives. Perhaps the targets should be reskewed, or at least the commissioners should be aware that the interventions are not without problems.

- At the end of it all, the effect of a successful intervention in absolute terms could be greatest in the poorest groups but the inequality gap (in relative terms) might still be widened.

- Summary documents, including Martin White's and Mildred's comments pertaining to this discussion will be circulated. **NICE**

- Then followed a discussion of how much time was expected of the members of the PDG and whether (and in what form) they would be recompensed for it, in the light of universities making academic units account for research time. The following statement was drafted to take account of the discussion:

  The Behaviour Change PDG of NICE requests a response from NICE on the following: **NICE**

  Given the recent requirement that universities in the UK must now undertake full economic costing of the research time of their staff, this PGD requests NICE to negotiate an Agreement with universities over recognition of participation of academics on its advisory committees. Such an Agreement should as a minimum cover the time agreed for meetings, preparation and other working time required between meetings and travel time.

  Background: Many academics not covered by personal development agreements, particularly those outside the clinical area, will increasingly need to carry out NICE duties as part of their annual leave entitlement should no Agreement exist between NICE and the universities. The MRC and similar bodies have forged such Agreements with the universities. GP practices are also paid a locum fee by NICE for the participation of practice members. The form of an Agreement between NICE and the Universities would be a matter for negotiation, and might or might not involve monetary payments.

  Without such an Agreement, NICE could find it difficult to maintain a high standard of academic participation and involvement and may struggle to fill its committees. The area of NICE likely to be most affected would be that of Public Health, which has a high level of non-clinical academic involvement.

7. Discussion of field work

Following a discussion of potential organisations/professions to involve in the fieldwork stage of the programme guidance development the following suggestions were made:

Organisations

- Primary Care Trusts - Chief Executive Officers
- Local Authorities
- Department of Health
- The Treasury
- Improvement and Development Agency
- Charities which deliver services
- Prison Services
- Custodial institutions
- Drop-in centres for homeless people
- Umbrella groups for voluntary sector
- Research Councils
- PCT – Professional Executive Committee (PEC)
- Social Exclusion Unit
- Nuffield Council
- Wellcome Trust
- British Medical Association
- Royal College General Practitioners
- Institute for Public Policy Research
- Faculty of Public Health
- Commission for Race Equality
- South Asian Health Foundation
- The Home Office - Respect Agenda

Professions

- Practice nurses
- Directors of public health
- Chair of school governor bodies
- Public health specialist
- Researchers designing behaviour change intervention
- Standard 1 leads for mental health

The idea of restricting the fieldwork stage to one locality, for example, Birmingham, was considered,

8.
Synopsis This item was not discussed.

10. AOB There was no other business.

DATE OF NEXT MEETING: 23rd February 2007

MEETING PAPERS TO BE MAILED: 12th February 2007