NICE PUBLIC HEALTH PROGRAMME GUIDANCE
BEHAVIOUR CHANGE
7th meeting of the Programme Development Group
30th and 31st May 2007, Royal College of Anaesthetists, London.

MINUTES

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

DAY ONE 30th May 2007

Agenda Item	**Minutes**	**Action:**
1. Welcome and introduction	The Chair welcomed members to the 7th PDG meeting. Apologies were received from Miranda Lewis, Miranda Mugford, Stephen Sutton, Robert West, Vicky Cattell, Clare Wohlgemuth, Roisin Pill and Jennie Popay. No changes were made to the group's declarations of interest.	
2. Minutes of last meeting	Agreed as a correct record.	
3. Presentation of field work report. Nigel Jackson	Nigel Jackson from Dr Foster Intelligence presented the findings from the fieldwork. <u>Overview</u> • Professionals welcome NICE guidance. • Their work context influences their response to guidance. • They are looking for how to do their work better (around behaviour change). • They seek clarification about training. • Respondents accept that they should be evaluating their work but indicate that this is hard to do due to financial constraints.	

Methodology
It was a piece of qualitative fieldwork which involved professionals in behaviour change across sectors. In total it included 91 individuals across 30 fieldwork units.

An agreed recruitment questionnaire was used to recruit professionals. Participants were also screened in order to achieve the diversity that the researchers were looking for. The fieldwork was conducted in London, Greater Manchester and the West Midlands.

Aims

The aim of the fieldwork was to examine the relevance, utility and implementability of the draft recommendations. For example, what is the relevance/usefulness of recommendations to current practice? What impact might the recommendations have on current policy?

Findings
The findings were presented to the group.

Perceptions of NICE & NICE Guidance

- Participants know what NICE is and what the organisation does.
- All participants use NICE guidance to inform their work and think it is generally well-drafted.
- All say that they use NICE guidance as they want to do things that work.
- They welcome the NICE guidance .

Use of models of attitude and behaviour change and their application

- Participants who use attitude and behaviour change models are generally positive about the guidance.
- Public health professionals are less likely to use models in their work.
- Practitioners who use models (clinical psychologists, marketing professionals) find working within a framework too rigid at times but know their model has been tried and tested and some contribute to continuing monitoring and evaluation of effectiveness.
- Participants who use models do so to develop:
  - Campaigns targeting populations and communities
  - Change programmes targeting individuals (e.g. drug prevention, smoking cessation, emotions management, etc).

Need for guidance

- Professionals who actively use attitude and behaviour change models generally understand what the recommendations are encouraging them to do.
- Those who use models believe the recommendations target them (regardless of sector or setting).
- Professionals want clearer cross referencing to the evidence to show how it works.
- Those who use behaviour change models less overtly can

find the recommendations too generic and difficult to understand/difficult to apply to their work.

Recommendation 1

- All participants agree that professionals should work in partnership with individuals, communities and populations. The list does not currently reflect this aspiration.
- All agree that they should take account of a local context. A few would like the recommendation to be clearer about how they do this.
- All agree that professionals should target specific behaviours and barriers to change; all say they strive to do this.
- Most are concerned that they will not have the funds or skills to evaluate effectiveness of their activities.
- Many say they do a needs assessment and think professionals should do a needs assessment before taking action. Some would like a clear steer on how to do this.
- Some participants felt that the recommendation suggests to only target individuals (not populations or communities).

Recommendation 2

- The recommendation was received positively.
- Practitioners think recommendation 2 is relevant to them too.
- Public health teams can see this as the role of local authorities and government.
- Several participants asked what is meant by 'positive social networks'.
- Commissioners are surprised that they only have to 'consider' investing in interventions and programmes that identify and build on the strengths of individuals and communities and relationships within them
- Several think that the list of activities is too vague and want greater specificity , e.g. in terms of recommending specific approaches to building resilience, self-esteem, and life skills
- Others think the list is too tightly specified and would like a longer list of recommended activities.

Recommendation 3

- Recommendation 3 was considered the most contentious.
- Participants want clarification about which specific policy makers, commissioners, and practitioners the recommendation refers to.
- Professionals accept the need to improve the evidence base.
- Participants queried how possible it is to carry out the recommendation within local restraints.
- Participants struggled over what the recommendation means with respect to scientific evaluation and said that if they are going to do it they need guidance on how to do it.
- Those who actively use attitude and behaviour change models say they generally do monitor and evaluate their activities; however, not necessarily scientifically.

Recommendation 4

- Some participants felt recommendation 4 duplicates recommendation 1. Others disliked the recommendation because the wording could be interpreted as being

discriminatory.

- Participants argued that ‘anyone’ can make a rational choice. They think identifying disadvantaged groups in this could be seen as patronizing and judgmental.
- All participants agreed that it is best practice to involve target populations in the development, evaluation and implementation of interventions.
- Participants recognised that structural improvements can be important to health improvements, including interventions to change physical environment; however, they think this duplicates recommendation two (i.e. to remove social, financial and environmental barriers to change)

Recommendation 5

- Practitioners agree that they should focus their resources on people who want to change their behaviour.
- Many practitioners believe they comply with these recommendations and find this reassuring.
- Some respondents though there was a danger of this recommendation being seen as a statement of the obvious.
- Commissioners said that they would like clearer recommendations or guidance on how best to achieve each of the above

Recommendation 6

- It is suggested that recommendation six includes managers of practitioners.
- It is suggested that clearer guidance is needed on what constitutes ‘appropriate training’.

Recommendation 7

- Some participants think that recommendation 7 duplicates recommendation 1.
- Respondents would like more specific examples in the recommendation.

<u>Conclusions from fieldwork</u>

The participants accepted that the recommendations are evidence based and no gaps were identified. However, most participants want greater specificity and examples given. They also want the recommendations to be made clearer i.e. separate individual/community/population levels. In addition, they would like the recommendations to have a title to show whether it is relevant to their work. Definitions should also be provided and repetition should be reduced.

<u>PDG Discussion</u>

The Chair congratulated Nigel Jackson on the fieldwork and said that it was well conducted.

General comments from PDG:

- A member asked whether respondents understood the difference between the terms ‘self efficacy’ and ‘self esteem’. Nigel Jackson said that most people don’t and it was the clinical psychologists who were most comfortable with the distinction..
- A comment was made that the more practical support that can be included in the guidance the better. Another

member noted that , it is hard to provide specific examples when the guidance is for a national audience with different local needs. Nigel Jackson agreed but said that it is an area people struggle with and therefore it is important to refer them to source documents.

- Mike Kelly asked if respondents are asking for a toolkit which the guidance could refer to. Nigel Jackson confirmed that this was the case. He added that he has a concern about putting specific examples in recommendations because people tend to take them literally but he added that it helps to put a reference to sources..
- It was observed that two groups of opinion emerged from the fieldwork; first that the recommendations confirmed and supported current practice and second that there was not enough specificity. .

Comments from PDG on recommendations:

- It was acknowledged that the recommendations need to be re-jigged to avoid confounding .
- It was noted that behaviour change is distinct from other public health guidance and reference should be made to other pieces of guidance involving behaviour change.
- It was recognised that the fieldwork is very valuable.
- A member said that the document is laced with concepts which are highly contested. It will be challenging to write a final document which prevents tribal reactions. Nigel Jackson reported that participants expected the guidance to outline theory in more detail.
- It was noted that some of the questions/issues raised i.e. development capacity are not things that this guidance should address.
- A member said that it would be useful to produce a web-based resource and supporting documentation. Nigel Jackson confirmed that participants did mention this type of resource and requested practical advice.
- It was agreed that the overlap between the recommendations needs to be revisited during the meeting and there needs to be clarity between monitoring and evaluation.
- A member suggested that the guidance should offer theory to professionals. They added that it is important that it is evidence based and it states which mechanisms are evidence based. Further more, the theory needs to be implemented in different contexts and it should be defined where it is appropriate in specific contexts.
- It was noted that there are words included in the guidance which not everyone will understand. Nigel Jackson agreed that complex terms should be used but the terms should be defined in a glossary.
- A member said that it is helpful to think about other process/health outcomes so that you can begin to assess.
- It was acknowledged that the Local Authority sector had not engaged as much in the fieldwork as had been hoped..

<u>Summary</u>

The Chair said that the issues to be considered the following day were:

- Giving clarity in terms of audience / definitions / vocabulary.
- How to deliver clear directions.
- Giving guidance on how to do it and whether this is appropriate.
- Separating recommendations out in terms of levels and dealing with overlap.
- Giving recommendations titles.

Issues to be considered in relation to the recommendations:

- Recommendation 1 – Seen as a useful checklist but people want more detail and the levels should be considered.
- Recommendation 2 – To be considered in conjunction with recommendation 1 and vocabulary to be thought through.
- Recommendation 3 – Regarded as the most contentious recommendation which has been interpreted in different ways; wording to be considered.
- Recommendation 4 – Seen as a duplication; to be considered whether it can be combined with recommendation 2.
- Recommendation 5 – Wording to be considered.
- Recommendation 6 – Very positive feedback but more detail on training requested. The group to consider whether this is appropriate.
- Recommendation 7 – There is a lack of clarity re levels. The group to discuss.

4.

Presentation by Catherine Swann

Relevant papers: Presentation attached.

Stakeholder comments.

It was suggested that there should be separate recommendations for motivated and non-motivated people. Previous suggestions had been provided by CA. **NICE**

It was pointed out that the stakeholder comments seem to suggest that we are concentrating on individual rather than population and community level interventions. This needs to be rectified. **NICE**

A discussion was held regarding the distinction between the levels of intervention (i.e. population, community and individual). Some definition of the terms should be offered, and the preamble or 'considerations' in the Guidance should make it clear that it is the level of delivery which is being distinguished.

Evaluation should be seen as part of planning.

'Flavour of the month' is a major factor influencing local funding and can lead to many interventions being short term. We should be aiming for long term benefits/solutions and long term evaluation.

A discussion was held re: the cost effectiveness of interventions. The main points were as follows: **NICE**

- It is important to consider which interventions are most cost effective. It would appear that the most cost effective interventions are the public goods i.e. goods which, apart from set up costs, can be provided free to the wider public,

often in the form of information. E.g. food labelling. RCT evidence is not needed to estimate the cost effectiveness of such goods.

- Resources should be placed where most public health gain can be achieved. It was suggested that big gains could be achieved via information campaigns and big gains are possible from focussing on subject areas e.g. Smoking and statins.
- Cost effectiveness should be an important consideration in making recommendations but there is not much cost effectiveness data available. Most evidence relates to effectiveness. We will be unable to weigh up the different modes of delivery and unable to quantify. Not sure this is right – any other suggestions?
- Ethically we should be promoting cost effective interventions but the evidence of effectiveness is not always available. **NICE**
- Population level information programmes may be cost effective but the PDG must be sure they are effective.

As discussion was held about how the recommendations could be organised. The following structures were suggested:

1. Designing, planning and monitoring.
2. Interventions for initiating and stimulating behaviour change.
3. Interventions supporting behaviour change.
4. Tackling resistance – focussing on groups with particular hurdles to behaviour change.

OR

Categorise by outcome measures of change eg.

1. Individual change in knowledge and attitude.
2. Community – eg. Perceived community cohesion may be an appropriate measure.

OR

Use heading of individual, community and population headings. Define how interventions are managed.

No decision was made on how the recommendations should be organised. It was agreed to develop a framework in the next iteration.

5. **Next Steps – Mike Kelly**	The PDG were asked to note that some stakeholder comments represent self interest and should be read as such in the final deliberations. Concern was raised that we may have strayed too far from the original referral. The referral states 'generic and specific interventions' but this guidance will focus on the generic rather than the specific. MK assured the PDG that this interpretation of the referral would be useful. It was agreed that we have focussed on the generic but the specific will be covered by cross referencing to other NICE guidance Environmental factors and health behaviour may be a piece of guidance for the future. The guidance will be about the instigation of behaviours as well as behaviour change. This should be signalled in the preamble if possible.	**NICE**
6. Consideration of additional evidence	It was agreed that the additional evidence submitted would not alter the structure of the current recommendations. The committee recommended that NICE should review this stage of the process. It was suggested that NICE should use expert input to advise on reviews before commissioning them. It was agreed that we would refer this to the NICE Technical Team	**NICE**

NICE

7. Costings

At present the NICE costing unit are unclear as to what costing material would be appropriate for the Behaviour Change guidance.

The following comments were noted:

- The Costing Team may be considering the issue from an accountant's perspective. A more creative approach may be required for this guidance. Costs to PCTs may not be relevant and consideration should be given to other sectors.
- Most 'public good' interventions are being done already, therefore there is no cost.
- We can expect this guidance to be low cost, no cost or cost saving.
- It was suggested that we should make a recommendation to PCTs on the cost to the NHS of different behaviour related diseases.
- Behaviour change can have a significant impact on morbidity and mortality across the society and therefore there will be significant cost savings.
- It was suggested that the team should look for indirect costs.
- The recommendations are more about how people do things than what they do.
- The costs of evaluation may be useful to PCTs e.g. 10% of project costs should be allocated to evaluation.
- Public health is a 'slow growing crop' and therefore we need to explain investment and return in the costings.
- It would be possible to use the example of the cost of lives saved from smoking cessation over the last 20 years.
- It would be possible to look at the literature on premature death and the burden of morbidity. For example cost the impact of one particular behaviour.
- It was suggested that the costs and saving of training could be explored as part of the costings project.
- A recommendation about training, unlike most of the other recommendations, has cost implications. If it is to be useful to planners, the recommendation should ideally give some idea of the resource use that would be implied, which in essence means its cost. In turn, that cost might need some justification in terms of the cost effectiveness, though the last would be virtually impossible to judge at all accurately.

It was agreed that the NICE team would speak to the costings team about the specifics of costing training including CPD and initial training.

8. Research recommendations

The Chair presented her paper containing five suggested research recommendations. A general discussion ensued during which the following points and suggestions were raised: -

- A new recommendation was suggested which proposed giving value to research which answers policy and practice questions rather than solely that which contributes to the Research Assessment Exercise (RAE), which tend to focus more on micro-level research.
- Priority should be given to research that reports on behaviour and its maintenance.

- It was noted that the PDG needed to make a distinction between research recommendations which were high level and national, and those that people were expected to undertake locally.
- The recommendations for research need to be made with *Appendix B – Gaps in the evidence* in mind.
- Addiction was a missing theme and perhaps needed a research recommendation.

Research recommendation 1

- This recommendation was widely supported. It was noted that the quality of research is often poor and that there is a need both for better research and better reporting.
- It was felt therefore that research recommendation 1 should also be aimed at journal editors.
- The CONSORT guidelines are a good example for research recommendation 1, but it was felt that a development of CONSORT and TREND is what is needed to effect a paradigm shift, although it was noted that CONSORT is specific to RCT's and something more generic would be needed in the long run.
- This could be framed as an Only In Research (OIR) recommendation.
- It was also suggested that the recommendation could reflect the importance of moving from a medical model to a social model.
- There is a need to be clear in this recommendation about what constitutes a 'health outcome'.

Research recommendation 2

- This recommendation could say something about the predictability of health inequalities
- There was some discussion about how specific research recommendations should be. Some members felt that they should be carefully crafted to be non-prescriptive since they drive research funding, others felt that they should be specific because of the need for systematic research into behaviour change.
- The committee noted that there was strong clustering of health behaviours and that research investigating the interconnectedness of these behaviours could be important in this recommendation.
- It is also important in this context to consider the collaboration of researcher and researched, for example in Action Research.

Research recommendation 3 & 4

- The Chair asked the committee whether they felt recommendation 3 was necessary.
- The committee felt that more evaluation of interventions was needed along with more research on relative effects of interventions.
- Behaviour change interventions rarely measure the mediators of change and these process and mechanism measures are important.
- There needs to be a clear distinction in this recommendation between in-service monitoring and 'proper' evaluation.
- There is also potential here to make a research

recommendation specific to the MRC, ESRC, AHRC etc.

Other general points which arose: -

- It is of key importance to distinguish between academic and in-service evaluation. The word 'scientific' should be removed from the general recommendations.
- In terms of understanding the population better there is the issue of culturally sensitive interventions, including SES sensitive interventions.

The NICE team would now draft research recommendations which will appear in the next draft Guidance and be discussed at the next meeting.

DAY TWO 31st May 2007

Agenda Item	Minutes	Action:
1. **Welcome**	Mildred Blaxter welcomed the group to the second day of discussion, directing them to work through the guidance document from the start.	
2. **Drafting public health guidance**	***Relevant papers: Draft guidance document, Fieldwork report, Stakeholder evidence***	
Mildred Blaxter	<u>Introduction, sections 1 &2:</u> The need for a statement on the status of the guidance (and / or a pre-amble that sets out what the document does and does not cover) was discussed. Mike Kelly explained that NICE has a form of words that explains the obligation on the National Health Service to public health guidance from NICE. It was suggested that a pre-amble could guide the user to consider this NICE guidance in conjunction with other, topic specific NICE guidance which it should be seen to complement, not replace. Mike Kelly explained that it would not be possible to change the referral title of the guidance. The 'key priorities' would be added later in the editorial process. The need for a glossary or set of definitions was raised once more. It was decided that the next draft should explain terms within the main text more clearly, and include a glossary of terms in the appendix. This should include terms such as 'intervention' and 'programme'.	**NICE**

There was discussion of the most appropriate term to use in order to consistently describe co-ordinated actions that aim to change health related behaviours: 'intervention' vs 'programme' was considered. A view was expressed that all possible terms – including campaigns, initiatives, schemes and policies – should be employed to ensure that all relevant professionals are reached.

It was suggested that a clear statement about different levels of intervention acting / being measurable at other levels was needed. A section in the scope addresses this issue: it was agreed to include it in the guidance document. It was noted that setting clear outcomes at the beginning of an intervention would make the expected change processes clear (the 'programme theory' of an intervention), although not all outcomes resulting from an intervention would necessarily be measurable or expected. **NICE**

Martin White suggested that it would be helpful to have a paragraph in this section defining intervention characteristics and offered to send a list to the NICE team for information. **Martin White**

An implicit assumption in discussions amongst the committee, that it is possible to change people's behaviour by changing health professional's behaviour, was suggested. The committee agreed that there was a balance to be struck between NICE guidance and professional judgement, and that guidance should aim to empower professionals to work with the evidence. The effectiveness of techniques for changing professional behaviour was discussed: Catherine Swann noted that she had commissioned Karen Jochelson and her colleagues at the Kings Fund, on behalf of NICE's implementation team, to carry out a rapid review of this area last year. This would be circulated to the PDG for information, and may be something that could be referred to topic selection for further guidance. **Catherine Swann / NICE**

It was noted that although the guidance set out to examine the impact of life stage / transition and also of inequalities / different social groupings on the effectiveness of attempts to change behaviours, little evidence was identified. The final paragraph of section 2 should acknowledge this. **NICE**

Summary of specific changes:

- Add a pre-amble section to the guidance
- Develop a glossary, and ensure terms are explained within the body of the text
- Section 2, last paragraph: Say more about what the guidance is about – add a sentence to the effect that the guidance is aimed at improving the quality and quantity of life

<u>Section 3: Considerations</u>

It was noted that there was negative feedback from stakeholders on section 3.1. Use of the word 'choice' was discussed. A stakeholder request was that reference be made here to the context in which behaviours are made. Suggestions for wording were invited from the committee, to be submitted by the 8th June. **ALL PDG**

The effect of the editing process on the sense and structure of the recommendations was discussed. The committee expressed dismay at many of the changes that had been made during the editing process, and asked the NICE team to ensure that regard **NICE team**

was shown to the language and nuances of the area. The committee agreed that it was important for the guidance to be written and presented in a way that made it accessible to the intended audience, but that this should not result in them being 'dumbed down'.

Section 3.4 was discussed and the need for re-wording and a different example noted. It was suggested that the point to get across here was the importance of professionals and practitioners not making moral judgements about behaviour, and seeing behaviours within the context that people inhabit.

Section 3.6 was observed to require some clarification: there may be consequences of intended and unintended outcomes, which may also be 'patterned' socio-economically. These consequences may be individual, social etc.

Feedback from stakeholders and the fieldwork, and discussion in the committee, indicated that changing the life chances of children would also require changes in the behaviour / knowledge of the adults that influence them (at home, school and so on). It was felt to be important that the guidance did not give an impression that resources should be geared towards working with children at the expense of working to change adult behaviour in section 3.11

Psychological and psycho-social models of behaviour change were discussed in relation to section 3.12. It was suggested that the first two sentences be deleted. A suggestion has been put to the NICE Topic Selection Committee that further guidance be developed on appropriate psychological models of behaviour change. Rephrasing of the final section of 3.12 was suggested to make it clear that the guidance did not consider all relevant models. The committee felt that they would like to return to an earlier draft of the recommendations in which investment in the Transtheoretical Model (or training in this approach) was explicitly discouraged.

The committee suggested reversing the position of 3.13 and 3.14 in the document. It was proposed that 3.14 should be expanded to acknowledge the level of evidence that exists on all interventions, and the fact that often, for intervention at this level to have significant impact, there needs to be a 'secular' trend in place.

It was noted that training and service development agencies are already available throughout the NHS. The need to be specific and clear about the type and quantity of training required (and for whom) was discussed. Charles Abraham offered to circulate a paper on intervention mapping to initiate thinking about the competencies required for intervention at different levels of activity.

Charles Abraham

Section 3.16 was considered by the committee. It was suggested that the effectiveness of 'fear' messages in health promotion and information campaigns be put forward to the Topic Selection Committee for intervention guidance.

NICE team

Other specific changes:

- 3.3 – expand on the groups mentioned to include age, gender, ethnicity.
- 3.4 – needs re-wording and a different example
- 3.6 – requires an explanatory sentence

- 3.7 – requires clarification
- 3.9 – replace ‘allowing’ with ‘enabling’
- 3.10 – this should be expanded to include protection against a number of factors, not just illness. Replace ‘vulnerable people’ with ‘people in vulnerable circumstances’

Recommendations:
A number of general points were noted with regard to the recommendations. These were: that the style / tone of the recommendations needed attention (they were not always considered to be clear); their arrangement / structure could be changed or improved; that headings or subheadings would be a useful tool, and that more detail was required in places.

A number of subheadings / ways of structuring the recommendations were suggested. The NICE team proposal for ‘Planning’ ‘Individual level’ ‘Community level’ ‘population level’ and ‘sustaining change’ were discussed. Other suggestions were that they could be ordered under ‘Planning’, ‘Delivery’ and ‘Evaluation’ (although evaluation should also be part of planning). ‘Planning’, ‘Design and Content’, ‘Delivery mechanisms’ and ‘evaluation’ were also proposed.

Recommendation 1:
The committee noted that a number of toolkits and other resources existed in the field in many areas where further detail had been requested by stakeholders. Further information on needs assessment and partnership had been requested. It may be necessary to add a consideration to section 3 on this subject.

Charles Abraham offered to circulate information about the Information, Motivation, Behaviour model (Geoff Fisher) — Charles Abraham

It was suggested that sections from recommendations 4, 6, and 7 could be combined with recommendation 1, under a general heading that referred to planning. To make the recommendation more clear, use of a ‘Rather than….’ example in each area, where appropriate, was proposed.

The recommendation should make clear that the content of each intervention should be described. It was suggested that practitioners should develop a protocol when designing interventions so that they can be replicated.

There was discussion about training needs and competencies. It was suggested that PCTs needed tools to help them do the job properly, and not academic discussion.

Access to R&D support to evaluate interventions could be costed, although in-house expertise would likely be cheaper, and thought was needed as to where external expertise might be found. Previously, national organisations such as the Health Education Authority had held central resources and tools for good practice and evaluation, but this function had not been taken on by another agency when the HEA was disbanded.

The committee concluded that there was a short-term need to evaluation and planning support, and a longer term need for training

and resource co-ordination in order to increase capacity. Researchers should also gain practice experience.

Performance management in the NHS would need to support the guidance.

Specific changes:

- Bullet point 3 of this recommendation would be best placed at the beginning.
- Remove brackets from the last bullet point
- Add ‘skills’ to the bottom of p9

Recommendations 2 & 4:
Feedback from stakeholders indicated that there was overlap between these recommendations, so the Chair directed the committee to consider them together.

The relationship between self-esteem and behaviour change was discussed, and a lack of direct evidence noted.

The nature of social, financial and other barriers was questioned. Meanings needed to be clear, as did to whom this recommendation applied – individual practitioners were unlikely to be able to tackle economic barriers to behaviour change.

Specific changes:

- Add examples of barriers
- Use ‘rather than’ to elaborate meaning

Redrafting the bottom bullet point of 2 was suggested, as resilient behaviour was likely to be motivated.

Recommendation 3
This recommendation should be more specific. Better evaluation research is needed. Again, tools and resources exist to provide people with more information on models and approaches themselves and NICE should not need to duplicate these.

A balance is needed, however – it should not necessarily be the case that ALL local projects should be evaluated.

The first bullet point of 3 would be better placed in recommendation 1. The remainder of this recommendation refers to intervention with individuals.

Discussion returned to the issue of models of health behaviour, and specifically the transtheoretical model. The committee expressed a view that they would like to see a recommendation on this reinstated here, possibly around disinvestment in training in the model.
Specific changes:

- Move bullet point 1 to recommendation 1.
- Include the TTM in this recommendation.

Recommendation 5:
Much of this recommendation could be joined with recommendation

1.

The committee agreed with feedback that different approaches were suitable for working with motivated vs unmotivated individuals. Material on this had been removed in the editing process. The committee asked that it be reinstated.

The lack of direct link between recommendation and evidence was also discussed. Again, this had been present in earlier drafts, but had been removed at the end of the drafting process. The committee asked that this link be reinstated.

Audiences for this recommendation were discussed. It was suggested that they include commissioners and providers, and that these be defined in the glossary.

There was discussion around the phrase 'aim to make it feasible' and agreement that 'aim to' should be removed. Charles Abraham agreed to provide more information to support this recommendation. — Charles Abraham

Specific changes:

- Remove 'aim to' from 'make it feasible'
- Reinstate link between evidence and recommendations
- Reinstate information about unmotivated individuals

Recommendation 6:
It was suggested that the phrase 'professional' or 'practitioner development' would be appropriate here. Access to tools and information should be included. Cultural competence was another key factor.

The committee discussed the possibility of mapping the competencies needed for public health intervention at different levels, and the fact that people working in different roles would need different competencies.

This recommendation was considered to relate to delivery and aspects of professional expertise. The issue of costing was raised again: Although many of the recommendations would be difficult to cost, it may be possible to gather sufficient information here. This recommendation should relate to existing training and development budgets (and the work of teaching public health networks / service development agencies), and could be cost-neutral or cost saving. However, work is needed to establish the level of cost.

Recommendation 7:
It was noted that interventions at all levels should be sustained over time. Charles Abraham suggested that the Re-AIM model (Glasgow et al) might be useful – to be circulated. Population policies such as food labelling could make decisions easier for people. — Charles Abraham

The committee asked that different examples be used, drawn from evidence considered here.

Specific changes:

- Add the point on sustaining interventions to recommendation 1.

- Change the examples used here
- List further examples of types of interventions

Drafting Guidance

The committee were invited to submit suggestions for other gaps in the evidence by the 8th June.

All suggestions or comments for inclusion in the next draft should be submitted by the 8th June.

NICE will email the latest draft to the committee on the 15th June, followed by an updated version on the 30th. PDG members will have tw opportunities to comment on successive drafts.

The guidance comes back to the committee on the 11th July for further consideration, and will be sent to Guidance Executive on the 31st July. Publication is due on the 26th October 2007.

Professor Blaxter thanked colleagues, and closed the meeting.

DATE OF NEXT MEETING: 11th July 2007

MEETING PAPERS TO BE MAILED: 2 July 2007