NHS
National Institute for
Health and Clinical Excellence

FIELDWORK ON GENERIC AND SPECIFIC INTERVENTIONS TO SUPPORT ATTITUDE AND BEHAVIOUR CHANGE AT POPULATION AND COMMUNITY LEVELS

Report

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Prepared for: Centre for Public Health Excellence (CPHE)

Prepared by: Nigel Jackson

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EXECUTIVE SUMMARY

1. Introduction

This report presents the findings of fieldwork on NICE CPHE programme guidance on generic and specific interventions to support attitude and behaviour change at population and community level. The main aim of the fieldwork is to explore the relevance, utility and implementability of the draft recommendations.

2. Our approach

We adopted a qualitative approach to fieldwork to enable us to explore views on the recommendations in depth and detail. In total, 91 professionals took part in the fieldwork across 30 fieldwork units in London, Greater Manchester and Birmingham. The fieldwork included professionals working:

- In policy development, commissioning and delivery
- At population, community and individual levels
- Nationally, regionally and locally (London, West Midlands and Greater Manchester)
- Across a diverse range of topics including nutrition, exercise, sexual health, smoking and substance misuse
- In policy making and commissioning (such as those working in the DH, other government departments and 'arm's length' bodies, national charities and PCTs, (including directors of public health, public health advisers and health promotion staff), and practitioners such as GP primary care teams, local charity staff and health trainers

Fieldwork was conducted locally in 'spearhead' PCTs to ensure we focused on attitude and behaviour change among vulnerable and hard-to-reach communities.

3. Summary of main findings

3.1 Perceptions of NICE CPHE draft recommendations

- Professionals want to do attitude and behaviour change work that is effective in order to ensure they contribute to PSA targets

- Consequently, they welcome the development of NICE CPHE programme guidance on attitude and behaviour change interventions

- Many consider this area of their work challenging due to the lack of any clear-cut evidence of effectiveness concerning specific interventions. They hope that the draft NICE CPHE guidance will tackle this

- Most think the recommendations are written in plain English and therefore understandable (some health trainers found it difficult to understand what they meant), but many find them hard to interpret and relate to their work:

    - Practitioners who use evidence-based models find the guidance reassuring and think they will be able to implement them, but other practitioners do not understand what they mean and what they are asking them to do

    - Policy-makers and commissioners at a national and local level agree that the recommendations reflect current practice, but do little more than this. As such they are perceived to add little value other than providing a checklist against which to ensure compliance

3.2 Draft recommendation one

Most participants agree with the activities listed and say they do at least some of them already, albeit not consistently. However, many agreed that the recommendation activity could be clearer. There were requests for clarification about:

- How NICE CPHE wants them to work in partnership with individuals and communities

- How NICE CPHE wants them to do a needs assessment

- What specific information they should take into account on local context

- How to assess people's existing assets, skills and abilities

- How to decide which specific behaviours to target and which barriers to tackle

- Whether they should prioritise interventions that tackle the individual beliefs, attitudes, intentions and knowledge associated with the target behaviours

Most are concerned that they would not have the funds or the skills to evaluate all their activities and, in particular, to determine cost effectiveness.

3.3 Draft recommendation two

Most participants agree with the activities listed, but some would like to see a longer list of approved activities. However, the perceived effectiveness of activities to tackle social, financial and environmental barriers is said to vary.

Practitioners think they can contribute to removing social, financial and environmental barriers by working with other agencies. Consequently, they think they should be listed under 'who should take action?'.

There is particular praise for encouraging local participation in local service planning.

Several participants want clarification about:

- What is meant by 'positive social networks' and how best to assess whether a social network counts as positive
- What techniques to use to effectively build resilience, self-esteem and life skills

3.4 Draft recommendation three

Participants know it is important to evaluate attitude and behaviour change interventions to improve the evidence base. However, they claim they do not have the funds or skills to evaluate everything effectively. Many want clarification about what is meant by 'clearly justify' and 'scientifically evaluate' any conceptual or psychological models used. They also want to know if this prohibits them doing anything and/ or using models if they lack the funds or expertise to evaluate them thoroughly.

3.5 Draft recommendation four

Most agree with the activities listed in recommendation four and say they already do them, but again not consistently. Several consider the recommendation repetitive of recommendation one and two. Several argue that anyone can make a rational decision to adopt behaviours that lead to poor health, not just people living in disadvantaged circumstances. Some participants want clarification on:

- How to assess need

- What information to gather on social and cultural context, and how best to use it
- How best to involve hard-to-reach groups in the development evaluation and implementation

3.6 Draft recommendation five

Practitioners involved in delivering attitude and behaviour-change interventions say they do target those motivated to change behaviour. They generally agree with the actions listed, e.g. in terms of planning for relapse. They think recommendation five gives a useful checklist against which to judge a complaint.

However, several practitioners ask whether recommendation five means they should not try to get people interventions who are not motivated to change their behaviour. Participants want to know how best to enhance and develop skills to help people make positive chance.

3.7 Draft recommendation six

All agree that staff should be trained. Many participants want clarification about what constitutes appropriate training. Managers ask whether staff have to be trained to plan, deliver, implement and evaluate before being allowed to do attitude and behaviour change work.

3.8 Draft recommendation seven

Participants agree with the activities listed under recommendation seven. Some think it again duplicates recommendation one in places. Some want clarification about what constitutes a population-level intervention. Others want clarification on:

- What information to gather about context, needs and behaviours
- How to deliver tailored interventions that are effective
- How to ensure interventions are sustained over time, for example in an environment when the NHS is constantly, such as being reorganised, undergoing budgets cut or central government priorities change

3.9 Gaps and improvements

- Several general improvements to the document are suggested, including:
    - A preamble which shares NICE CPHE's challenges in developing the guidance to manage expectations better upfront (i.e. the poorly-developed evidence base and the importance of evaluation going forward)
    - A title or brief synopsis of the recommendation to enable professionals to judge whether is relevant to their work
    - Make recommendations clearer (i.e. what are you encouraging me to do, especially in terms of specific activities at individual, community and population level)
    - Give more examples to make the recommendations more tangible, applicable across subjects, sectors and settings
    - Separate different levels of activity more (e.g. individual, community and population levels); participants find it hard to interpret precise meaning (i.e. does prioritise interventions that target individuals mean don't do community and population level work?)
    - Provide definitions, or a glossary of terms:
        - Who counts as a policy-maker, commissioner and practitioner
        - Who counts as a disadvantaged or socially-excluded group, e.g. health inequalities start at C2DE, so are we talking about asylum seekers, homeless, chaotic drugs users, etc?
    - Reduce repetition (e.g. multiple references to monitoring and evaluation)
    - Clarify the status of the recommendations (i.e. do I have to do this?)
    - Relate the recommendations to the evidence more explicitly (e.g. cross referencing)
    - Give guidance on how to determine compliance with the recommendations, including audit criteria (i.e. given their perceived lack of specificity within the

recommendations commissioners think it will be hard to know if they are compliant)

- Give greater guidance within the recommendations or subsequent implementation support about measuring outcomes
- Give more guidance on implementation in the recommendations or clearer cross referencing in the recommendations that additional information is available on how to implement the recommendations, including coverage of effective tools and techniques for achieving attitude and behaviour change

A. INTRODUCTION

The Department of Health (DH) has asked the Centre for Public Health Excellence (CPHE) at the National Institute of Health and Clinical Excellence (NICE) to develop guidance on: *"The most appropriate means of generic and specific interventions to support attitudes and behaviour change at population at community level."*

The guidance targets professionals working in the NHS, in central and local government and the voluntary sector, who have either a direct or indirect role and/or responsibility for policies, programmes or interventions, which are aimed at changing health attitudes, beliefs and behaviours. It includes recommendations concerning interventions to change health-related knowledge, attitudes and behaviours at individual, community and population level, taking life-stage and other relevant factors into account.

The guidance, its scope and recommendations have been developed by the Behaviour Change Programme Development Group (BC PDG) after:

- An extensive review of the best available evidence on effectiveness and cost effectiveness
- Stakeholder consultation

Unlike other areas of NICE CPHE public health guidance, which deal with specific topics or intervention types, the guidance on behaviour change is wide-ranging and will concern public health commissioners, policy-makers and researchers, as well as professionals and practitioners, who work with the general population and particularly those who work with vulnerable or hard-to-reach communities.

Fieldwork represents a key stage in the development of NICE CPHE guidance. Details of the full process for the development of NICE CPHE public health programme guidance can be found at: http://www.nice.org.uk/page.aspx?o=300584. Findings from the fieldwork are an important source of evidence on the feasibility of implementation of the guidance, and the conditions required for uptake and delivery.

Fieldwork findings are considered by the BC PDG during the drafting of the final guidance, due to be issued in October 2007.

The final scope takes a broad-based view of behaviour change. In summary, the guidance aims:

- To set out the range of behaviour-change models, policies and approaches
- To set out what the available evidence says about the effectiveness of each
- To make recommendations about their future use across topics, audiences, settings, delivery models, together with evidence and research requirements

The CPHE recognises the importance of getting robust feedback from the professionals who will ultimately implement the recommendations made within the guidance to ensure that:

- The recommendations are based on current policy and professional practice, values and beliefs to maximise their relevance
- The recommendations tackle any potential external opportunities and barriers that may affect the implementation of any recommendations
- The assessment of the evidence on which the recommendations are based is considered sufficiently robust
- The recommendations are considered relevant, useful and feasible by professionals across professions, settings, and levels

To this end, it commissioned Dr Foster Intelligence to conduct the fieldwork stage of the guidance development process.

B. OBJECTIVES AND RESEARCH QUESTIONS

The main research objectives are:

- To examine the relevance, utility and implementability of the recommendations with policy-makers, commissioners and practitioners with particular reference to vulnerable and hard-to-reach communities

The main research questions are:

- What are the views of practitioners on the relevance and usefulness of these recommendations to their current work or practice?
- What impact might the recommendations have on current policy, service provision or practice?
- Which factors such as service configuration, training could impact, either positively or negatively, on the implementation and delivery of the guidance?
- Do practitioners know of any evidence, either from their own experience and practice or elsewhere, not currently taken into account by the recommendations?

C. OUR APPROACH

1. A qualitative approach

We adopted a qualitative approach for the fieldwork. The flexible and iterative nature of qualitative enquiry enables us to explore what different audiences think of the guidance in depth and detail. It also enables us to check comprehension of the recommendations and consider their detail, complexity and implications thoroughly.

2. Group discussions and depth interviews

Where possible, we conducted group discussions. Group interaction enables participants to trade views and experiences, and to formulate more informed viewpoints in the process. It enables them to 'hot house' any positive and/ or negative issues associated with the recommendations and their implementation. It also enables them to work more creatively, e.g. to develop solutions to any issues identified.

Attendance at group sessions was between three and 10 people, and lasted around 90 minutes. Groups consisted of homogenous participants, in terms of professional group, role and responsibilities to ensure that a group dynamic developed. This also helps us to segment the sample and analyse the resultant data, e.g. by role, profession, etc.

However, it proved difficult to convene groups with many different professionals within the timescale available. Therefore, group discussions were supplemented with individual depth interviews. These generally lasted around one hour.

3. Recruitment

Participants were recruited using an agreed recruitment questionnaire (appended). All recruitment was managed in-house to ensure quality standards. We recruited the following participants in-house:

- Department of Health (DH) staff
- Other government department representatives
- National charity representatives
- Strategic health authority decision-makers and staff
- Primary care team staff

Our team developed a long-list of potential participants. We invited them – by post or email – to take part. We then called two days later to establish interest in participation within the available timescales.

Given the tight timescales, we adopted a flexible approach to fieldwork. We aimed to conduct group discussions of eight participants. We over recruited to ensure numbers on the day (10 for eight on the day). If all 10 turned up, we interviewed them. Where a group discussion did not come together, we replaced it with individual and paired depth interviews to make up numbers.

Some frontline staff were recruited via PCT staff. We are extremely grateful for all their help and support with the process. Other healthcare professionals and local charity representatives were recruited via our network of professional recruiters.

We reimbursed any locum fees and travel expenses incurred where necessary to enable health professionals to take part.

4. Sample achieved

We would usually aim to include a minimum of 12 participants per sample cell to generate robust qualitative data and to enable us to generalise about a particular population group. Below this we generally consider findings indicative. In summary, 97 individuals took part in the fieldwork across 30 fieldwork units in London, Greater Manchester and the West Midlands. Consequently, the data generated is robust at the level of the sample as a whole. Participants were recruited using a recruitment questionnaire, which is appended.

We screened the sample to ensure they covered a broad range of topics, including:

- Nutrition
- Sexual health
- Emotions management
- Parenting skills development
- Smoking
- Substance misuse (drug and alcohol)

- Mental wellbeing
- Cancer prevention

Participants were screened to ensure use of a diverse range of both generic and target approaches, including:

- Information-based interventions (including brief interventions)
- Advertising campaigns across mass media
- Marketing, PR, public affairs and other communications
- Policy interventions (e.g. standards for school meals)

We indicate robustness below. In summary, we included the following.

4.1 Department of Health (DH)

DH staff are involved in developing legislation, policy and campaigns to encourage behaviour change. In summary, we conducted:

- 2 x depths with DH civil servants involved in health improvement/ social marketing

We consider findings robust[1] at the national level (n=15), but any findings specifically from civil servants are indicative only given the small numbers in our sample.

It is important to note that many DH civil servants felt that they had already been consulted during the drafting of the recommendations and, consequently, most declined to take part.

[1] We would usually aim to include a minimum of 12 participants per sample cell to generate robust qualitative data and to enable us to generalise about a particular population group. Below this we generally consider findings indicative.

4.2 Other government departments and 'arm's length' bodies

A wide range of other government departments are actively involved in attitude and behaviour change work e.g. the Home Office's Frank Campaign, or the Department for Education and Science's Healthy Schools Campaign, etc. In summary, we conducted:

- 1 x group of five participants
- 2 x depth interviews

We consider findings robust at the national level (n=15), but any findings specifically from other government departments and arms' length bodies are indicative only.

4.3 National charities

Many national charities conduct attitude and behaviour change work themselves, or on behalf of government (e.g. Cancer Research UK's Sun Know How Campaign is funded by the Department of Health). Therefore, we were keen to include them in the fieldwork stage. In summary, we conducted:

- 1 x group of four staff from national charities
- 2 x individual depth interviews

We consider findings robust at the national level (n=15), but any findings specifically from national charities are indicative only.

4.4 SHA DPHs

We wanted to get the views of strategic health authority (SHA) directors of public health (DPH) who oversee large areas of the country. We conducted:

- 2 x depths

(*Total involved = two individuals)*

Findings are indicative only at a regional level/ for SHA DPHs.

4.5 PCT directors of public health (DPHs)

Directors of public health are responsible for the health of their local population. They develop policy and commission work at a community or individual level across all health improvement topics. Therefore, we included:

- 3 x depths with directors/ assistant directors (including one from a joint local authority/ PCT team)

We consider findings robust at a local level (n=80), but any specific findings from the directors of public health are indicative only due to the small number involved.

4.6 Public health advisers and health promotion staff

Public health advisers can be involved in policy development, health promotion, commissioning and liaison with other local organisations. They can span work based on clinical and social models of health. In summary, we conducted the following:

- 1 x group of 10 public health advisers/ public health staff
- 3 x trios
- 5 x individual depths

Findings for public health advisers and health promotion staff are robust (n=24).

4.7 Practitioners

We wanted to include professionals who work face-to-face with individuals to change attitudes and behaviours. We refer to them as practitioners. We consider findings robust at practitioner level (n=53).

4.7.1 Primary care teams

Primary care delivers attitude and behaviour change activities across a wide range of topics, including smoking, substance misuse, sexual health, nutrition and exercise. Therefore, it is essential that they buy into and implement any NICE CPHE guidance. In summary, we conducted:

- 2 x group discussions with 10 professionals in each (including a mix of GPs, practice nurses, community midwives, health visitors and school nurses)
- 1 x group discussion with nine health advisers working in sexual health and family planning, London

Findings for primary care teams are robust (n= 29).

4.8 Health trainers

Health trainers will play an increasingly important role in changing attitudes and behaviours towards health. As a relatively new role within NHS services, we were keen to involve them. In summary, we included:

- 1 x group of 10 health trainers, Greater Manchester
- 1 x group of six, London
- 1 x depth interview with a health trainers co-ordinator, Birmingham

We consider findings for health trainers robust (n=18).

4.9 Local charities

We wanted to involve charities that are involved in attitude and behaviour change work locally, either independent of the NHS and/ or funded by PCTs. We wanted to see the extent to which they were willing to follow them or use them as best practice guidance. In summary, we conducted:

- 1 x trio
- 3 x depth interview

We consider findings at a local level robust (n=74), but findings for local charity workers are indicative only (n=6).

4.10 Other sectors

We had wanted to include local authority staff and representatives of strategic partnerships. However, all of those we approached declined to take part, and referred us back to the PCT whom they believed led on attitude and behaviour change. This included those with joint commissioning teams.

5. Conducting the group discussions

The recommendations were pre-placed with group participants to give them time to consider them in depth and detail in advance of the group. This enabled us to cover them more thoroughly during group sessions. Group were conducted using an agreed discussion guide (appended). In the event, it proved difficult to use the planned self-completion exercises and shufflecards because participants had so much to say about the seven recommendations and their detail.

6. Geographic spread

Fieldwork was conducted with staff working nationally (all London-based) and regionally (West Midlands SHA and North West SHA). All fieldwork with local professionals was conducted in areas designated as ‘spearhead’ PCTs, i.e. areas of high deprivation. This enable us to make sure that staff involved in behaviour change work had a particular interest in tackling health inequalities and working with populations living on very low incomes. We aimed to include staff working in urban and

rural areas. Fieldwork was conducted across Greater Manchester, the West Midlands and London. We also aimed to include at least one rural area.

7. Analysing the response

All fieldwork was tape recorded and transcribed verbatim. Researchers also took fieldnotes in case of any difficulties with recordings. A summary of the qualitative data obtained was entered into a grid using an Excel spreadsheet. Each fieldwork unit was summarised along an individual row within the grid. Each column represented a specific theme or response to a specific recommendation. Columns were analysed and a summary of the main themes was included at the end of each column.

Verbatim quotes have been used throughout the report to illustrate the points made. They have been anonymised to ensure confidentiality. Where the population is small we have excluded location to preserve anonymity (e.g. regional co-ordinators, directors of public health, etc).

D. MAIN FINDINGS

1. Perceptions of NICE and NICE guidance (including CPHE guidance)

- All participants know NICE and understand what it does. They know it reviews the evidence and makes recommendations to the NHS about what staff can and cannot do, e.g. in terms of prescribing etc.

- All participants use NICE guidance (including public health guidance). Participants make positive references to guidance on obesity, anxiety and depression, reducing underage conceptions, tackling substance misuse among vulnerable young people:

    - NHS professionals review practice against the guidance and adapt what they do and how they do it to ensure they are compliant

    - GPs and directors of public health often delegate such activities to relevant staff and are generally less engaged with the detail of NICE guidance

    - National and local charities use NICE guidance when they think it is helpful to do so, i.e. they use it as best practice rather than mandatory

- NHS staff believe that they are bound to implement NICE guidance to the best of their abilities. They expect NICE recommendations to 'tell' them what to do.

    - Other professionals think they provide useful best-practice guidance, but do not believe they have to comply. (This made recruiting them difficult, because they cannot always see how such outputs are relevant to their work)

    - Voluntary organisations commissioned by PCTs to deliver public services are unsure whether they have to abide by the recommendations when delivering such interventions

- However, the status of NICE CPHE public health guidance was not well understood:

    - Some NHS staff such as public health advisors and health promotion staff consider it mandatory (e.g. public health advisors and health promotion staff), while others consider it discretionary because it is perceived to offer guidance on best practice rather than rules that must be followed

  - Charity staff both nationally and locally were unclear whether or not they were expected to implement public health guidance recommendations, for example when commissioned by the statutory sector to run services and campaigns on behalf of the NHS

- All praise the existing NICE guidance for being easy to read and understand, and for its specificity in giving clear direction.

- However, there is some criticism about the amount of NICE guidance that practitioners have to take into account during any one year, especially among those working across issues and areas such as GPs and directors of public health. They complain that implementing it is time-consuming and would prefer the guidance to be limited with phased introduction.

- All say they use NICE guidance because they want to commission/ do things that work and there is considerable support for evidence-based practice.

- However, many also say that evidence-based practice should not hinder innovation and creativity, for example where the evidence is insufficient to give clear direction. They also recognise the need to monitor and evaluate any innovation to contribute to the evidence, but believe lack funds and relevant skills can limit capacity to do so.

2. Use of models of attitude and behaviour change and their application

- We interviewed clinical psychologists and frontline practitioners who use evidence-based models of attitude and behaviour change such as the Webster Stratton Parenting Model, Maudesley Smoking Cessation Model, etc. A few say they use in-house models, but acknowledge that these have not always been evaluated.

  - Comparatively few public health professionals say they use conceptual models in designing policies and programmes (e.g. the stages of behaviour change model, health action model and health beliefs model)

- Practitioners know their model has been tried and tested and some contribute to continuing monitoring and evaluation of effectiveness; as such, they are confident that their approach is evidence-based.

- They can find working within such a framework too rigid at times.

- We also interviewed professionals involved in social marketing activities who use conceptual models and/ or market segmentations (e.g. the Integrated Model of Behaviour Change to underpin their work, including public health professionals involved in such work).
    - They believe the use of such models helps them to work in a more structured and consistent way
    - They think it helps to ensure that they use a consistent set of performance measures and measure success more effectively
- Overall, Prochaska and DiCelemente (Stages of Behaviour Change) was the most frequently cited model:
    - Many also know that its practical application has been questioned in recent years, because it describes the population, but does not set out a sequential model and therefore is perceived to be of little practical application
- Public health professionals working in 'spearhead' PCTs often say they have looked at conceptual models as part of their work, but do not use them consistently.
    - They are trying to change a wide range of behaviours, e.g. smoking, nutrition, exercise, sexual health, substance misuse, etc, and often want clear direction on how best to do this to help them achieve their PSA targets
- In summary, 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)
- A few say they adapt attitude and behaviour change models to fit with their requirements. For example, some find the models too broad-based and generic, while others find international models are not directly applicable to their specific area and alter them to fit with specific circumstances (e.g. drug use among adolescents).

- National and local charity staff interviewed did not generally use attitude and behaviour change models to underpin their work (e.g. campaigning or individual behaviour change).

- Overall, many find attitude and behaviour change work difficult to do. They think it needs greater investment and more/ better co-operation across organisations and sectors, especially in terms of tackling health inequalities.

3. Overall perceptions of the recommendations

- Many acknowledge the need for NICE CPHE guidance on *generic and specific interventions to support attitude and behaviour change at population and community levels.*

    - Several professionals working in different settings believe that money is often wasted on ineffective and poorly-focused attitude and behaviour change work, especially in relation to work trying that targets socially-excluded audiences and, in particular, in terms of community level interventions

    - Consequently, they want definitive and effective guidance to help ensure effective use of public funds

- Most agree that the recommendations are easy to read in terms of the language used, however many find it hard to understand or interpret precisely what they asking them. Some health trainers found them hard to understand. They currently work to a health trainer handbook and are unclear whether or not they need to take account of these recommendations. They assume the handbook would be adapted by their co-ordinator to ensure compliance with the recommendations.

- Practitioners who use attitudinal or behaviour models in their work with individuals are generally more positive than others about the recommendations, e.g. using psychological models of behaviour change:

    - They understand the recommendations

    - They believe the recommendations closely reflect how they currently work

    - As such, they think the recommendations:

  - Target them
  - Will be easy to implement (they are doing most already)
  - Give them a useful checklist against which to check compliance
  - Provide reassurance that they are doing the right thing (i.e. they are often relieved that they will not have to change their current practice much)
  - Will help others to be more compliant

- Other practitioners, who do not use models can find the recommendations hard to understand and apply to their work.
- Professionals working at a community or population level acknowledge the lack of evidence-based approaches for attitude and behaviour change at these levels.
  - They themselves would like to adopt more evidence-based ways of working to ensure they use public funds more effectively
  - They would like to see greater consistency in approach across the country and expect NICE CPHE guidance to deliver this outcome
  - They accept that it is difficult for NICE CPHE to make clear recommendations in the absence of any evidence
  - However, they do not believe the recommendations as they stand will help them to meet their objectives (i.e. cost-effective working, greater consistency in approach across the country) due to their perceived lack of clarity and specificity
  - They can struggle to understand what the recommendations are asking them to do and call for more examples throughout to help them relate them to their work. Switching between individual, community and population-level interventions causes particular confusion (e.g. “if a recommendation refers to individual level only does this mean I cannot do community and population level work?”)
  - Overall, they are often disappointed with the recommendations as they stand and consider them too vague to have any real impact on their work or that of others. A few think NICE CPHE should not be making recommendations if the evidence is so weak

- The *Public health need and practice* section sets high expectations by promising against what the recommendations are perceived to not adequately deliver:
    - Effective strategies for intervening at the individual, community and population levels to change people's knowledge, attitudes and behaviour in relation to their health including the opportunities and consequence of intervening at key transition points
    - Strategies for reaching and working with disadvantaged groups
- A few suggest rather than providing guidance about how to intervene, the recommendations provide a high-level, best-practice framework about what is possible.
- Many recognise the challenge NICE CPHE has making evidence-based recommendations on attitudes and behaviour change, because of the perceived lack of evidence base of effectiveness.
    - They agree that the evidence-base needs to be improved and that monitoring and evaluation play an important role in helping to ensure evidence-based recommendations in the future
    - However, many admit that they do not consistently evaluate their activities and do not always feel they have the skills or the funds to do so, including those working at population, community and individual levels
    - Several are concerned that the emphasis within the guidance on evaluation may discourage organisations from doing attitude and behaviour change work, i.e. they believe the recommendations suggest that they should only do such work if they are prepared to evaluate it
    - Few believe recommendations encouraging evaluation will have any impact due to their current resource constraints
- Overall, many professionals:
    - Acknowledge that the recommendations reflect good practice
    - Say they do most of them already, as such they will be easy to implement

- Acknowledge they should do the others (i.e. evaluation)

- However, several are disappointed they do not tell them anything new and as such will not make a significant difference to current practice and help them to make a significant impact on health inequalities.

"They are all relevant. How workable they are is a little questionable?"

Depth, national charity, London

"I couldn't actually work out the use of them. They are too bleeding obvious!"

Director of public health, Greater Manchester

"Is this something that we are obliged to put in place or is it just a summary of best practice?"

Depth, public health advisers, West Midlands

"I wouldn't see it as an obligation as such – a very useful checklist, but not an obligation."

Group, national charities, London

Why is the evidence base important?

"You need something that gets results, time and time again. You want to base your practice on something that works."

Group, public health advisers/ health promotion, Greater Manchester

"It's a bit repetitive. That causes confusion!"

Group, public health advisers/ health promotion, Greater Manchester

"This does what every other white paper does, and tells us what we already know."

Depth, director of public health, Greater Manchester

"This isn't guidance on how to implement behaviour change as far as I can see… apart from the blindingly obvious."

Depth, director of public health, Greater Manchester

4. Detailed response to the draft recommendations

Below we outline the response to each individual recommendation.

4.1 Recommendation 1

4.1.1 What the draft recommendation said

Who should take action?

Policy-makers, commissioners and practitioners whose work impacts on people's health-related behaviour or who wish to change health-related behaviour.

What action should they take?

- Work in partnership with individuals, communities and populations to plan and implement interventions and programmes to change health-related behaviour. These should:
  - Be based on a needs assessment or knowledge of the target audience
  - Take account of the local context in which people live, especially the socio-economic and cultural context
  - Be based on an explicit plan which sets out which behaviour is to be targeted and why, which interventions will be delivered, what the content of the intervention will be and which outcomes will be measured and how
  - Develop and build upon people's existing assets, skills and abilities
  - Target specific behaviours (for example, encourage people to eat five portions of fruit and vegetables a day, rather than simply instructing them to 'eat a healthier diet') and barriers to change (for example, lack of access to information or resources)

- Prioritise interventions and programmes that:
  - Can be tailored to tackle individual beliefs, attitudes, intentions and knowledge associated with the target behaviour
  - Can be consistently delivered and supported at more than one level, for example, locally by GPs, nationally by a media campaign and across more than one setting such as in primary care and schools
  - Use key lifestages or times when people are more likely to be open to change, e.g pregnancy, entering or leaving school and entering or leaving work.
- Ensure that sufficient time and resources are set aside to evaluate effectiveness and cost effectiveness.

4.1.2 What participants said about it

- Everyone is clear who this targets, i.e. all professionals at all levels involved in behaviour change.
- All agree that professionals should work in partnership with individuals, communities and populations:
  - They assume this means patient and public engagement and involvement (including outreach, qualitative research, surveys, etc)
  - Many strive to do this in relation to attitude and behaviour-change work
  - However, several think the actions suggested do not fulfil this aspiration
  - Several want specific examples to illustrate what they are expected to do
- Many say they do needs assessment and think professionals should do a needs assessment before taking action.
  - A few would like a clear steer on precisely how NICE CPHE wants them to do a needs assessment, how to decide who and what to target in the first place and what information to use in the process (especially in terms of hard to reach populations)

- A few admit they could do this more consistently
- A few say “knowledge of the target audience” is too vague and insufficiently systematic
- GP primary care teams see needs assessment as the role of PCT public health teams rather than practitioners working face-to-face with people who want to change their behaviour

- All agree that they should take account of local context (including socio-economic group and cultural context).
  - All say they do do this
  - A few would like the recommendations to be clearer about precisely how NICE CPHE wants them to take account of local context
- Many admit that they do not always have an explicit plan(s), and that the plan that they do have doesn’t always set out which behaviours are targeted and why, which interventions will be delivered, what content is included, and in particular, what outcomes are measured.
  - All agree with this recommendation, but have concerns about resource implications in terms of the funds and skills necessary to measure outcomes consistently
- All agree that professionals should develop people’s existing skills and assess. All say they strive to do this.
- All agree that professionals should target specific behaviours and barriers to change. All say they strive to do this.
- When asked to prioritise interventions that tackle individual beliefs attitudes, intention and knowledge associated with specific behaviour(s).
  - Those involved in campaigning work ask whether this means they should not do community or population-level work

- Most agree that activities should be delivered across levels and settings, i.e. to ensure an integrated approach and to maximise impact

  - GP primary care teams believe they can have only limited impact on attitudes and behaviour. They believe national advertising and local public health campaigns can have greater impact than they can in motivating attitude and behaviour change

  - Consequently, they see most of the recommendations as important, but not directly relevant to them

- Many say they do target key lifestages (e.g. pregnancy, diagnosis with specific diseases, entering hospital, etc), especially GP primary care teams who recognise that this is when they can often intervene most effectively

- Most are concerned that they will not have the funds or skills to evaluate the effectiveness of their activities, especially cost effectiveness, due to the lack of health economists working within the NHS.

"How can I disagree with it! It's like motherhood and apple pie really, isn't it?… It's simply describing what happens already."

Depth, health trainer, West Midlands

"What's useful is things that are practical, things that people can relate to. I'm not sure how helpful these will be in terms of helping [people] in real circumstances."

Depth, national charity, London

"I find it really hard to imagine that people who were involved in this content are actually going to come back with evidence of cost effectiveness. Where are the skills going to come from?"

Group, national charities, London

"I initially panicked. 'We can't use our local model anymore, because it's not evaluated'. Having read it again, we're not going against the recommendations, but I guess we should evaluate it."

Group, public health advisers/ health promotion, London

"I wouldn't be fazed if someone put that on my desk and asked me to deliver it. What we are poor at is documenting what we are doing. We don't always capture and tell everyone what we are doing and how well we are doing it. So, it's right that evaluation is in there...."

Group, public health advisers/ health promotion, Greater Manchester

"Well, you can't really fault what it says, but it's just how are we going to get the other partners to buy into it."

Depth, director of public health, Greater Manchester

4.2 Recommendation 2

4.2.1 What the draft recommendation said

Who should take action?
Policy-makers and commissioners working with communities, especially those working with disadvantaged and excluded groups.

What action should they take?

- Identify and attempt to remove social, financial and environmental barriers to change.

- Consider investing in interventions and programmes that identify and build on the strengths of individuals and communities and the relationships within those communities. These include interventions and programmes to:
  - Promote parental skills and enhance child/ carer relationships
  - Improve self-efficacy
  - Develop and support positive social networks and nurturing relationships (for example, extended kinship networks and other ties)
  - Support organisations and institutions that offer opportunities for local participation in service planning and delivery, or in terms of leisure, voluntary and paid activities
  - Promote resilience and build skills, relationships and self-esteem

4.2.2 What participants said about it

- Practitioners say they can contribute to removing social, financial and environmental barriers to change by working with other agencies, e.g. via integrated care models

- Public health teams working in areas where joint commissioning is well established say they do work with housing, welfare rights, Jobcentre Plus, etc, to achieve this.
  - However, others say this is very difficult to do locally, in areas where joint working is less well established
  - They believe central government and local authorities have more influence over such issues than the NHS

- Commissioners are sometimes 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.

- There is widespread support for encouraging investment in the activities listed, especially among voluntary sector staff who advocate a holistic 'life-skills' approach to attitude and behaviour change.

- In terms of detail, some ask for clarification on what is meant by a 'positive social networks' and who decides whether or not a network is positive, e.g. a professional or the individual themselves (a few suggest extended kinship networks can be the source of the problem in socially-deprived communities).

- There is particular praise for encouraging support of organisations and institutions that offer opportunities for local participation in service planning and delivery; all agree such patient and public involvement is best practice.

- Several think the list of activities is too vague and want greater clarify, e.g. in terms of recommending specific approaches to building resilience, self-esteem and life skills.

- Others think that the list is too tightly specified and would like a longer list of recommended activities.

"It's relevant, but how are you going to remove social, financial and environmental barriers to change? It all sounds very good, but all I would be saying is how to all of these."

Depth, national charity, London

"We need the willingness of other partners who actually do think about that, we need health to be higher up their (local authority) agenda."

Depth, director of public health, Greater Manchester

"The only thing that I've got an issue with is when it says about justifying and scientifically evaluating?"

Group, sexual health advisers, London

4.3 Recommendation 3

4.3.1 What the draft recommendation said

Who should take action?
Policy-makers, commissioners, curricula developers and practitioners.

What action should they take?
- Clearly justify and scientifically evaluate any conceptual or psychological models that have been used to design and deliver an intervention.

4.3.2 What participants said about it

- Many consider recommendation 3 the most contentious.
- Participants often want clarification about which specific policy-makers, commissioners and practitioners the recommendation refers to. For example, many ask what a curricula developer is, but equally assume curricula developers will know who they are. Some suggest that scientific evaluation is a job for academics and that these should be listed here.
- Those who actively use attitude and behaviour-change models say they generally do monitor and evaluate their activities. However, not necessarily scientifically (e.g. through randomised/ controlled trials)
- Several public health professionals question the value of investing in large-scale quantitative evaluation of their local activities.
- Many want clarification about:
    - Why it is necessary to 'clearly justify' and 'scientifically evaluate' their work
    - Precisely what is meant by 'scientifically evaluate' and will NICE CPHE provide additional guidance on how to do this?

  - Whether it is necessary to scientifically evaluate an already tried-and-tested model, especially if using an international or overseas model that is being applied in a domestic setting (e.g. Webster Stratton)
  - Whether this means qualitative evaluation and retrospective evaluation are not valid
  - Whether this means they don't have to scientifically evaluate activities if they don't say they are using a conceptual or psychological model
  - Where the funds are going to come from to ensure they do this well in terms of buying in skills, developing capabilities locally, etc. Many say this would be prohibitively expensive for their organisation
  - What this really means for practitioners. Several suggest practitioners should be expected to contribute to scientific evaluation, but not deliver a scientific evaluation in its entirety. GP primary care teams see evaluation as the role of academics and not them

- Those who don't use behaviour change models can interpret this as saying anyone doing attitude or behaviour change work should scientifically evaluate their work, especially those working in the voluntary sector. They think this would inhibit much needed action to tackle health inequalities, etc.
- Some stress the importance of:
  - Building evaluation in from the outset of an intervention
  - Setting clear objectives against which to evaluate
  - Including evaluation both pre and post-intervention (they suggest that retrospective evaluation is commonplace at present, but does not measure impact effectively)
  - Evaluating both intended and unintended outcomes
- Others highlight the difficulty of:
  - Measuring the impact of public health interventions on health

  - Proving a causal link between a public health intervention and health improvements/ disease prevention outcomes

- They want more detailed guidance on what outcomes to measure, and how best to measure them

"I think they should say is we shouldn't be setting up programmes that don't have some element of scientific evaluation, but I think we need help with it [evaluation]."

Depth, health trainer, West Midlands

"What does it mean? Does it mean that everything should be evidenced?"

Depth, local charity, West Midlands

"If they are hard to reach, how are you going to involve them in designing the evaluation?

Depth, national charity, London

"Commissioners, practitioners, curricula developers – what are they?"

Group, health trainers, Greater Manchester

"If I'm an, I don't know, environmental health officer in a local authority, you know, what actually are you asking me to do?"

Depth, SHA director of public health

4.4 Recommendation 4

4.4.1 What the draft recommendation said

Who should take action?
Policy-makers, commissioners and practitioners working with disadvantaged and excluded communities.

What action should they take?

- Acknowledge that people who live in disadvantaged circumstances may make a rational decision to adopt behaviours that can lead to poor health by:
  - Assessing the target population's need for an intervention
  - Gathering information on the social and cultural context in relation to the target behaviours, to gain an understanding of why the target community has adopted them
- Involve the target population in the development, evaluation and implementation of the intervention.
- Consider introducing structural improvements to help people who find it difficult to change behaviours that can have a poor effect on their health. Structural interventions could include changes to the physical environment.

4.4.2 What participants said about it

- A minority consider recommendation four contentious
- Several dislike its wording, especially those working in the voluntary sector, and consider the drafting of this recommendation judgmental.
  - They argue that anyone can make a rational decision to adopt behaviours that can lead to poor health, not just people from disadvantaged circumstances

  - They think identifying disadvantaged groups in this way is patronising and judgmental
  - They think there are also many other emotional reasons why

- Several think recommendation four duplicates recommendation one, in terms of assessing a target population's need for an intervention and gathering information on social and cultural context.
- Some GP primary care team staff and other public health advisers think the return on investment of intervening with people living in disadvantaged circumstances is low, because they are not motivated to change.
  - Although they recognise the importance ethically of tackling health inequalities, they question the efficacy of targeting resources disproportionately at such communities
  - They highlight the importance of working with community leaders and outreach with disadvantaged communities
- All agree that it is best practice to involve target populations in the development, evaluation and implementation of interventions (albeit this can be hard to achieve with seldom-heard groups); several want clarification on precisely how to do this
- They recognise that structural improvements can be important to health improvements, including interventions to change the physical environment:
  - However, they think this duplicates recommendation two (i.e. to remove social, financial and environmental barriers to change)
  - GP primary care teams believe this is often particularly key (e.g. encouraging drug users not to return to the environment where they use, intervening with obese families rather than individuals within the family)

"If that is meant to say that people 'choose' not to be healthy when they're poor, I find that an objectionable statement, and I'd say what's your evidence for it… There is a risk of a whole set of attitudes behind some of this terminology that we have to be really, really careful about."

Depth, health trainer, West Midlands

"Does this mean if they are not motivated you leave them alone? I do sometimes go in thinking 'am I banging my head against the wall?'."

Group, public health advisers/ health promotion, Greater Manchester

"Hasn't it already said this? It's a bit repetitive."

Group, public health advisers/ health promotion, Greater Manchester

"'…Assessing a target population's need for an intervention'. Please! It's insulting to practitioners that they wouldn't do that."

Depth, director of public health, Greater Manchester

4.5 Recommendation 5

4.5.1 What the draft recommendation said

Who should take action?
Commissioners and practitioners working with people who are motivated to change their health-related behaviour.

What action should they take?

- Provide interventions that:
  - Aim to make it feasible for people to change their behaviour
  - Enhance and develop people's skills to help them make positive changes
  - Help and support individuals to plan in advance for situations where they might feel tempted to revert to behaviours which could damage their health.
- Focus on the feasibility of change and its benefits.

4.5.2 What participants said about it

- Practitioners (especially GP primary care teams) highlight the importance of focus on people who want to change their behaviour.
  - Some think it is a waste of their resources trying to motivate people to change behaviour, rather than enabling those who want to change to do so
  - Others think it is important to try to motivate people to change, and accept limited success
- When working with people motivated to change, participants agree that interventions should aim:
  - To make it feasible for people to change their behaviour (and to focus on the feasibility to change)
  - Enhance and develop people's skills to help them make positive change

  - Help and support individuals to plan in advance for situations where they might feel tempted to revert to behaviours which could damage their health

- Many commissioners and practitioners believe they comply with these recommendations and find this reassuring (especially in terms of planning for relapse).

- However, commissioners would often like clearer recommendations or guidance on how best to achieve each of the above.

  - Several ask for additional guidance on how best to assess whether or not someone is motivated to change their behaviour

- Several question whether this means if people are not motivated to change, an intervention should not be delivered.

"I may not even try to discourage a 17-year-old male from smoking dope, as he will have no desire to try and stop. I would be more motivated to try and tackle something like domestic violence or sexual health."

Group, GP primary care teams, West Midlands

"You might assess for readiness to change, but if they are not interested then you would give them information and go back to them later, but not deliver an intervention. It's the way it's worded here. Does it mean 'don't intervene if they are not motivated'?"

Group, public health advisers/ health promotion, Greater Manchester

"The language is fine, but there's nothing really that you can take away from it… nothing new in there."

Group, health trainers, Greater Manchester

"That's exactly what we do!… We do all of those things!"

Depth, director of public health, Greater Manchester

"I think it would be good if they could flesh it out with some concrete stuff."

Group, sexual health advisers, London

4.6 Recommendation 6

4.6.1 What the draft recommendation said

Who should take action?
Policy-makers, commissioners and employers of practitioners whose work impacts on people's health-related behaviour or who wish to change health-related behaviour.

What action should they take?

- Ensure everyone who is involved in delivering interventions to change people's health-related behaviour receives appropriate training.
- Ensure appropriately trained professionals plan, deliver, implement and evaluate interventions and programmes aimed at changing people's health-related behaviours.

4.6.2 What participants said about it

- Several suggest that recommendation six should include managers of practitioners (responsible for staff appraisal, performance management and development planning). They think of employers as the organisation.
- All agree that staff should be trained.
    - However, managers and commissioners suggest that clearer guidance is needed on what constitutes "appropriate training" (e.g. national standards for smoking cessation training)
        - They can find it hard to get a sufficient budget to train staff, and think more detail here could help to give them the leverage they need to assure that appropriate training is available
        - They can also find it hard to encourage GP primary care teams to attend suitable training; they think greater specificity could help to compel GP compliance with recommendations about training

  - Some also suggest continuing professional development (CPD) should also be highlighted here

- Some managers suggest that it could present a challenge to their organisation if only those staff trained can plan, deliver, implement and evaluate interventions and programmes, i.e. does this mean that staff without appropriate training cannot work on such activities?

- Others suggest that the recommendation should make it clearer about what training should cover and what approach to training should be adopted.

"We're all in the business of changing behaviour ultimately, and it's completely pointless unless the person's adequately skilled… all people will end up doing is just telling [clients] what to do and giving them a load of advice…."

Depth, director of public health, Greater Manchester

"You should include employers in there too. They have access to training budgets for staff. You identify your training need with your manager."

Group, public health advisers/ health promotion, Greater Manchester

"We are certainly training our practitioners in behaviour change. I think they need to be trained more, further down the line and cascading down."

Trio, public health advisers, West Midlands

4.7 Recommendation 7

4.7.1 What the draft recommendation says

Who should take action?
Policy-makers and commissioners whose work impacts on people's health-related behaviour.

What action should they take?

- Gather information about the context, needs and behaviours of the target population(s).
- Use this knowledge to deliver tailored, population-level policies, interventions and programmes aimed at changing health-related behaviours. These include:
  - Fiscal and legislative interventions, for example, taxation and age restrictions on certain behaviours
  - National and local advertising and mass media campaigns
  - Point-of-sale promotions and interventions
- Ensure that population-level interventions are sustained over time, and are consistent with messages and interventions delivered at the individual and community-level.

4.7.2 What participants said about it

- Participants think recommendation 7 duplicates recommendation 1 in terms of encouraging professionals to gather information about the context, needs and behaviours of the target population.
- Participants involved in policy, legislation and social marketing activities welcome acknowledgement of their contribution to achieving behaviour change, but expected the recommendations to give a clearer steer on how to do such activities well/ effectively. As such, they are not clear on what NICE CPHE is asking them to do.

- Participants ask for clarification of what is meant by population-level interventions; they ask for specific examples to be given.

"It's particularly irritating that they do a needs assessment for a new project that someone did five years ago that worked and worked well. They're always reinventing the wheel. People get very angry with that."

Group, public health advisers/ health promotion, Greater Manchester

"I think it's great if it's taken on board. At the national level they do like what they've done for smoking, we do that about alcohol, we do it about obesity, we do it about physical inactivity, it will be great, because it will be much easier for us to slot our local work into that framework."

Depth, director of public health, Greater Manchester

5. Overview: gaps and improvements in the attitude and behaviour change guidance

- All accept that NICE CPHE has done a thorough review of the evidence and few gaps are identified:
    - One participant suggested that NICE CPHE should have looked at patient compliance models and lifestyle risk prevention models within the scope of this study
    - Another wanted to see greater emphasis on joint working across agencies and sectors
    - Another wanted to see greater reference to culture diversity and context throughout the guidance (albeit, they noted, that this was mentioned in places)
- Several expected them to say more about the theory and how to relate this to practice in the guidance and recommendations, and the training needed to ensure it is implemented effectively.
- Several general improvements to the document are suggested; many participants wanted greater specificity, greater clarity throughout the recommendations (once

explained, they accept that this can be difficult for NICE CPHE to do due to lack of evidence):

- Include a preamble which shares NICE CPHE's challenges in developing the guidance to manage expectations better upfront (i.e. the poorly-developed evidence base and the importance of evaluation going forward)
- Include a title or brief synopsis of the recommendation to enable professionals to judge whether relevant to their work
- Make recommendations clearer (i.e. what are you encouraging me to do, especially in terms of specific activities at individual, community and population level)
- Give more examples to make the recommendations more tangible, applicable across subjects, sectors and settings
- Highlight different levels of activity more (e.g. individual, community and population levels); participants find it hard to interpret precise meaning (i.e. does prioritise interventions that target individuals mean don't do community and population-level work?)
- Provide definitions, or a glossary of terms:
  - Who counts as a policy-maker, commissioner and practitioner
  - Who counts as a disadvantaged or socially-excluded group, e.g. health inequalities kick in at C2DE – so are we talking about asylum seekers, homeless, chaotic drugs users, etc?
- Reduce repetition (e.g. multiple references to monitoring and evaluation)
- Clarify the status of the recommendations (i.e. do I have to do this?)
- Relate the recommendations to the evidence more explicitly (e.g. cross referencing)
- Give guidance on how to determine compliance with the recommendations, including audit criteria (i.e. given their perceived lack of specificity within the

recommendations commissioners think it will be hard to know if they are compliant)

- Give greater guidance within the recommendations or subsequent implementation support about measuring outcomes

- Give more guidance on implementation in the recommendations or clearer cross referencing in the recommendations that additional information is available on how to implement the recommendations, including coverage of effective tools and techniques for achieving attitude and behaviour change

"I guess the sort of person it's useful for is a director of public health. It gives them a kind of high-level background to the implementation of behaviour change at their level, but it doesn't say 'try this one and not that one, this one is better than that one'. It doesn't give you that kind of stuff. What it gives you is a general kind of narrative. It's more a narrative, I think, than anything else."

Depth, Department of Health, London

"Okay. Well, I suppose my general reaction was that the recommendations are a bit general. I'm sorry if that's unhelpful, but…."

Depth, SHA director of public health

D. CONCLUSIONS AND RECOMMENDATIONS

1. Professionals generally understand the recommendations and think they are relevant to their current practice.

2. Professionals generally say they do the activities listed in the recommendations, and that setting them out in this way (i.e. as a useful checklist) will encourage them to do them more consistently.

3. Practitioners are generally relieved and reassured that their current practice is evidence-based and complies with the NICE CPHE guidance (i.e. the recommendations will not mean a significant change in current practice).

4. Policy-makers and commissioners working in areas of high deprivation such as 'spearhead' PCTs can find changing the attitudes and behaviours of their local population challenging:

    - This is an area of work which many find challenging, not least because it forms part of the core DH standards

    - They are looking for ways of radically improving their current work to ensure they meet PSA targets

    - They think the recommendations need to be more specific and directional to be truly useful and add value to their work

5. Overall, professionals generally think the recommendations will have limited impact on policy, services and delivery as they think most of the recommendations are common practice.

6. Ideally, professionals would like clearer guidance on *how* to do the activities listed within the recommendations well/ effectively. They are not always clear on precisely what the recommendations expect of them.

7. Professionals agree training is important and would like more guidance on what constitutes appropriate training to help ensure funding is made available locally to meet training requirements and to encourage primary care teams to reach an appropriate level of expertise.

8. Professionals accept there is a need to improve the evidence-base and think it is particularly useful to use the exercise to highlight gaps in the evidence (albeit they are substantial in the case of attitude and behaviour-change interventions).
    - Against this back-drop, they accept that greater emphasis has to be placed on evaluation to do this
    - However, they question the feasibility of extensive evaluation of existing activities without additional funding to buy-in out-of-house support and/ or the development of in-house capabilities
9. Superficially, professionals think the recommendations will be easy to implement, because they are already doing the activities listed; however, they are concerned that the recommendations are too broad-based and generic to know if they are doing them sufficiently well/ how to measure outcomes and performance.
10. Professionals can think of few gaps in the evidence reviewed; however, they want to see numerous improvements in their drafting;
    - Include a preamble which shares NICE CPHE's challenges in developing the guidance to manage expectations better upfront (i.e. the poorly-developed evidence-base and the importance of evaluation going forward)
    - Include a title or brief synopsis of the recommendation to enable professionals to judge whether is relevant to their work
    - Make recommendations clearer (i.e. what are you encouraging me to do? especially in terms of specific activities at individual, community and population level)
    - Give more examples to make the recommendations more tangible, applicable across subjects, sectors and settings
    - Highlight different levels of activity more (e.g. individual, community and population levels)
    - Provide definitions, or a glossary of terms
    - Reduce repetition (e.g. multiple references to monitoring and evaluation)

- Clarify the status of the recommendations (i.e. do I have to do this?)
- Relate the recommendations to the evidence more explicitly (e.g. cross referencing)
- Give guidance on how to determine compliance with the recommendations, including audit criteria (i.e. given their perceived lack of specificity within the recommendations commissioners think it will be hard to know if they are compliant)
- Give greater guidance within the recommendations or subsequent implementation support about measuring outcomes
- Give more guidance on implementation in the recommendations or clearer cross referencing in the recommendations that additional information is available on how to implement the recommendations, including coverage of effective tools and techniques for achieving attitude and behaviour change

11. Ultimately, the usefulness of the guidance will depend on the quality of the practical advice on how to implement the guidance, national initiatives that can give support, and audit criteria to monitor local practice highlighted in the implementation section. Signposting this clearly in the body copy may help to provide the additional reassurance that many professionals are looking for in relation to their attitude and behaviour-change work.

APPENDICES

1. **Recruitment materials**
2. **Discussion guide**
3. **Draft recommendations**

1. Recruitment Materials

National Institute for Health and Clinical Excellence

MidCity Place

71 High Holborn

London

WC1V 6NA

Tel: 020 7067 5800

Fax: 020 7067 5801

Email: catherine.swann@nice.org.uk

www.nice.org.uk

BEHAVIOUR CHANGE PROGRAMME GUIDANCE

I am writing to ask you to help us with a very important stage in the development of our Behaviour Change Programme Guidance. We have asked Dr Foster Intelligence to conduct the fieldwork stage of the programme guidance development process. They will be conducting 20 group discussions with professionals involved in encouraging knowledge, attitude and behaviour change. We want to get your feedback on our draft recommendations. We need your input to help us make sure our recommendations are relevant, useful, feasible and implementable. Therefore, your feedback will be a tremendous help. We are especially keen to involve professionals working with populations most likely to experience health inequalities to make sure that they can use the recommendations drafted.

Anything you tell us will be treated in the strictest confidence. No individuals or organisations will be identified when we report the findings.

I do hope you will be able to take part in this important project. If you have any queries about the research, please contact Dr Catherine Swann (technical lead) at NICE on 020 7067 5800 or Amanda Buckland (research manager) at Dr Foster Intelligence on 020 7332 8886.

Yours faithfully

Dr Catherine Swann

Recruitment Questionnaire

Hello, my name is …….. and I am conducting research for Dr Foster Intelligence on behalf of NICE.

NICE is developing Behaviour Change Programme Guidance. It has asked us to consult health professionals to get their views on the draft recommendations in the guidance. NICE wants to make sure its recommendations are relevant, appropriate, feasible and implementable.

The session will be held at……..

…….

on……..

the start time will be……..

I have just a few short questions…

Q1. Are you involved in (please tick):

Developing policy to encourage people to change their behaviour?	
Developing campaigns to encourage people to change their behaviour?	
Developing other behaviour-change activities?	
Commissioning behaviour-change activities?	
None of the above	

ALL PARTICIPANTS TO BE INVOLVED IN BEHAVIOUR CHANGE POLICY, CAMPAIGNS AND OTHER ACTIVITIES?

Q2a. At which level do you work?

Population-level activities	
Community/ area-based activities	
Individual-level activities	

Other (specify)_____	

CHECK QUOTAS AND RECRUIT AS PER SPECIFICATION.

Q2b. Which type(s) of behaviour are you trying to change?

Smoking	
Drinking	
Drug use	
Diet	
Exercise/physical activity	
Mental wellbeing	
All the above	
Other (specify)_____	

ENSURE GROUPS INCLUDE A MIX OF BEHAVIOURS TACKLED.

Q3. Which of the following best describes your role?

Decision-maker/ director	
Manager/ commissioner	
Practitioner / frontline staff	
Volunteer	
Other (specify) _____	

Q4. Can I just check whether you work in any of the following areas?

The Department of Health		Check quotas and recruit for G1
Other government department		Check quotas and recruit for G2
An 'arm's length' body		
A national charity		Check quotas and recruit for G3
An SHA (strategy health authority)		Check quotas and recruit for G4
GP primary care		Go to Q4
Other community settings		
A PCT (primary care trust)		Go to Q5
Local strategic partnership members		Check quotas and recruit for G10 and G 11
Other local authority		Check quotas and recruit for G17 and G18
Local voluntary sector organisation		Recruit a mix of staff working with communities or individuals passing through transition points – show card 1

Q5. If you work in GP primary care or other community setting, which of the following best describes your role?

GP	
Practice nurse	
Health visitor	
District nurse	
School nurse	
Environmental health officer	

Health promotion/ public health specialist	
Teenage pregnancy co-ordinator	
Health trainer	
Local authority (other)	
Other (specify)_____	

RECRUIT A MIX OF GP PRIMARY CARE TEAM AND COMMUNITY HEALTH STAFF FOR G13 AND G14; RECRUIT HEALTH TRAINERS ONLY FOR G15 AND G16

Q6. If you work in a PCT, which of the following best describes your role?

Director of public health		Check quotas and recruit for G5 and G6
Public health adviser involved in commissioning		Check quotas and recruit for G7 and G8
Health promotion practitioner involved in delivering behaviour change activities		Check quotas and recruit for G11 and G12
Other (specify)_____		

CHECK QUOTAS AND RECRUIT AS APPROPRIATE:

Name:

Address: **Telephone number:**

Mobile number: **Email address**

SHOW CARD 1

Recruit a mix for voluntary sector at Q4

- Preconception and planning pregnancy
- Pregnancy and first-time parenthood
- The first year of life
- Starting pre-school education (age 3)
- Starting primary education (age 4+)
- Age 7 (this age has been shown to be influential in terms of the relationship between education achievement and health outcomes)
- Age 11/ beginning secondary education
- Become sexually active/ first long-term relationship
- End of secondary education (age 16 or 18)
- Entry to tertiary education
- Start of paid employment
- Marriage and long-term relationships
- Menopause and mid-life
- End of dependent parenting
- Divorce and relationship breakdown
- Redundancy/ unemployment
- Early onset of chronic disease
- Retirement/ end of paid employment
- Later life (55+)
- Engagement in caring for older dependents
- Dying and death

NICE BEHAVIOUR CHANGE PROGRAMME GUIDANCE

Pre-task

Please read through the draft recommendations attached. You will be expected to take account of them when they are published, so please make a note either on the document or in the boxes below on:

- Which you consider is relevant to you
- Which you consider is useful
- Which you think are feasible and implementable and which you think are not
- Which will change what you currently do and how they will change things

Relevant

Useful

Feasible and implementable **Not feasible and implementable**

Change things and how

PLEASE REMEMBER TO BRING THIS NOTE WITH YOU

2. Discussion Guide

Role/purpose	Discussion guide
Understanding the context	• Warm up and introduction • Name and role • Responsibilities in relation to behaviour change (PROMPT for policy level vs commissioning vs delivery)
	• What areas of behaviour change do you work in • What models have you considered? Which do you use and why? • What particular approaches do you follow? Why? • Which approaches have you considered but not used – why?
	Using the draft changes which have been placed with participants as an aide memoire…
Overall response to the recommendations	• What was your initial response to the guidance? • What did you like/ dislike? – PROBE FULLY the reasons why • In general, how relevant, useful, feasible was the guidance? PROBE FULLY the reasons why • How easy or hard do you feel they would be to implement? Why • What are the barriers to implementation? • What would help or hinder implementation? • What would be needed to bridge the gap between theory and practical implementation? What tools? What training? • How much of an impact do you feel the guidance would have on policy, commissioning and/ or practice?

	(N.B. vary according to relevance for group) • To what extent do you feel the recommendation overall will improve your work? • Overall, how useful do you feel the recommendations will be to you and your professional group? How useful will they be to the populations, communities and individuals you work with? (PROBE for specific vulnerable groups) How could the usefulness be improved?
Working through each of the recommendations individually, moderators should check the following…	***Note: depending on role some recommendations will have more relevance than others – so note who is the intended audience as context for response*** ***Spend most of your time on the recommendations of direct relevance to that audience – therefore, rotate order of considering recommendations in favour of those directly relevant*** ***However, be aware that some recommendations may impact on their role even though not directly targeted at their role***
Self completion to minimise group effect	***Moderator to pass around self-completion sheets to record, individually, initial reaction to each recommendation*** ***Self-completion form :*** • *Is it relevant to you? (yes/no)* • *Would you put it into practice? (yes/no) Why?* • *How useful is it?* o *Very useful* o *Fairly useful* o *Not very useful* o *Not at all useful* • *On a scale of 1 to 10 , how much impact would it have on your current practice (0 = no impact; 10 = huge impact)* **Relevance/ usefulness** • ***Using self completion to identify diversity of response…*** • How relevant is this recommendation to you and your work? Why?

	• Would you put it into place? Why? • How useful would the recommendations be? Why? • Which individuals/ communities/ populations would it be most useful for? Why? • On a scale of 1 to 10 how much of an impact would it have on your work? Why? • What do you currently do and why? • What, why, how and when would you do things differently? • How could it be made more relevant to your area of work or the populations/ communities/ individuals you work with? • PROBE FOR specific vulnerable groups, lifestyles, health issues, etc • Benefits/ drawbacks
	Feasibility/ implementability **(gap between theory and practical implementation)** • How practical do you feel this recommendation is overall? • How easy/ difficult is it to implement? Why? • What are the barriers/ issues with implementing this recommendation? • What would you need to make it happen? What help would you require to bridge the gap between theory and practical implementation? (service, resources, training, configuration) • What is required to make it happen? • What are the potential/ negative impacts, if any? How can these be ameliorated? Why? • Are there any other factors which would help or hinder the implementation of this recommendation (e.g. service configuration, setting, population served, delivery, etc)? Why?
	Credibility ***Using self completion to identify diversity of response…*** • How confident are you that it is the right recommendation? Why?

	• How confident are you that it is based on the best available evidence? Why? • To what extent would this affect your willingness to adopt the recommendation? • To what extent does the fact that NICE has produced the recommendations play a role? • How could the credibility be enhanced and why?
Specific issues to probe for specific recommendations	**Recommendation 1** • What do you currently do in partnership with communities, populations and individuals? • How effective is it? • What are the benefits and drawbacks of working in partnership with individuals, communities and populations to plan, implement interventions and programmes to change health-related behaviour? • What would be needed to implement each of the following points? • How would the XXXXXX?
	Recommendation 2 • What attempts do you make to remove social, financial and environmental barriers? • How would the recommendations change or enhance the way you work? • What do you feel is required to remove the social, financial and environmental barriers? • What help do you need to achieve this?
	Recommendation 3 • Extent to which you already justify and scientifically evaluate any conceptual or psychological models that have been used to design or deliver an intervention – why/ why not?

	• Benefits/ drawbacks to doing this?
	Recommendation 4 • To what extent is the fact that disadvantaged groups may make a rational decision to adopt behaviours that can lead to poor health? And is it currently acknowledged? • How/ why? • How easy or difficult would it be to involve the target population in the development, evaluation and implementation of the intervention? Why? • What's required to do this? • How easy or difficult would it be to make structural changes? Why? • What's required to do this?
	Recommendation 5 • *NOTE: this recommendation applies to commissioners and practitioners* • To what extent do you work with people who are motivated to change their health-related behaviour? • What sorts of areas do these relate to? • How would this change the way you do things? • What would you need to be able to implement the recommended interventions?
	Recommendation 6 • What sort of training to you feel is required? • What would be required to implement this? • What is needed to ensure that appropriately-trained professionals plan, deliver, implement and evaluate interventions and programmes aimed at changing people's health-related behaviours? Why?

	Recommendation 7 • To what extent do you already collect information about the context, needs and behaviours of the target population? • What are the advantages/ disadvantages of collecting this information? • What would be needed to implement this? • What are the benefits of delivering tailored population-level policies, interventions and programmes? • What would be needed to deliver these? (Ask for fiscal and legislative interventions, national and local advertising and for point-of-sale promotions and interventions) • What would be needed to ensure that population-level interventions are sustained over time? • What would be needed to ensure that they are consistent with interventions delivered at the individual and community level?
	Importance, gaps and improvements • ***Having worked through the recommendations individually …*** • Which of the recommendations are most relevant to your area of work? • Which are the ones which are most important to your area of work? • ***Encourage participants to not just think about the ones which are targeted at their role – but the ones which might impact upon their role too, e.g. those relating to policy may also impact on practitioners even if not directly targeted at them*** • Which of the recommendations are least important to you?
Ranked order of importance	• ***Ask respondents to use shuffle cards to rank the recommendations in order of importance to them and their role*** • ***Ask respondents to explain the rationale behind the ranking***

	• Is there anything you would have expected which is not included in the recommendations (especially any evidence of effectiveness)? If so, what and why? • Are there any other improvements which could be made to the recommendations? • What impact would these improvements have on your willingness to adopt the recommendations? Why? • What else could NICE do to encourage uptake of the recommendations and communicate these to your profession?
Summary	• In summary, what are the top priorities and why? • What three things would you want the Institute to do next in relation to the proposed recommendations and why?

3. Recommendations

NICE CPHE draft recommendations

When writing the recommendations, the PDG (see appendix C) considered a range of evidence including the evidence of effectiveness and cost effectiveness. Note: this document does not constitute the Institute's formal guidance on this programme. The recommendations are preliminary and may change after consultation.

Appendix A lists details of the theoretical and methodological literature used to interpret the evidence, the evidence reviews and additional evidence.

The evidence reviews, other evidence, supporting evidence statements and the economic appraisal are available on the Institute's website at www.nice.org.uk

Recommendation 1

Who should take action?
Policy-makers, commissioners and practitioners whose work impacts on people's health-related behaviour or who wish to change health-related behaviour.

What action should they take?

- Work in partnership with individuals, communities and populations to plan and implement interventions and programmes to change health-related behaviour. These should:
  - Be based on a needs assessment or knowledge of the target audience
  - Take account of the local context in which people live, especially the socio-economic and cultural context
  - Be based on an explicit plan which sets out which behaviour is to be targeted and why, which interventions will be delivered, what the content of the intervention will be and which outcomes will be measured and how
  - Develop – and build upon – people's existing assets, skills and abilities
  - Target specific behaviours (for example, encourage people to eat five portions of fruit and vegetables a day, rather than simply instructing

them to 'eat a healthier diet') and barriers to change (for example, lack of access to information or resources)

- Prioritise interventions and programmes that:
  - Can be tailored to tackle individual beliefs, attitudes, intentions and knowledge associated with the target behaviour
  - Can be consistently delivered and supported at more than one level (for example, locally by GPs and nationally by a media campaign) and across more than one setting (for example, in primary care and schools)
  - Use key life stages or times when people are more likely to be open to change(such as pregnancy, entering or leaving school and entering or leaving work).

- Ensure that sufficient time and resources are set aside to evaluate effectiveness and cost effectiveness.

Recommendation 2

Who should take action?
Policy-makers and commissioners working with communities, especially those working with disadvantaged and excluded groups.

What action should they take?
- Identify and attempt to remove social, financial and environmental barriers to change.

- Consider investing in interventions and programmes that identify and build on the strengths of individuals and communities and the relationships within those communities. These include interventions and programmes to:
  - Promote parental skills and enhance child/ carer relationships
  - Improve self-efficacy
  - Develop and support positive social networks and nurturing relationships (for example, extended kinship networks and other ties)
  - Support organisations and institutions that offer opportunities for local participation in service planning and delivery, or in terms of leisure, voluntary and paid activities

  - Promote resilience and build skills, relationships and self-esteem

Recommendation 3

Who should take action?
Policy-makers, commissioners, curricula developers and practitioners.

What action should they take?

- Clearly justify and scientifically evaluate any conceptual or psychological models that have been used to design and deliver an intervention.

Recommendation 4

Who should take action?
Policy-makers, commissioners and practitioners working with disadvantaged and excluded communities.

What action should they take?

- Acknowledge that people who live in disadvantaged circumstances may make a rational decision to adopt behaviours that can lead to poor health by:
  - Assessing a target population's need for an intervention
  - Gathering information on the social and cultural context in relation to the target behaviours, to gain an understanding of why the target community has adopted them
- Involve the target population in the development, evaluation and implementation of the intervention.
- Consider introducing structural improvements to help people who find it difficult to change behaviours which can have a poor effect on their health. Structural interventions could include changes to the physical environment.

Recommendation 5

Who should take action?
Commissioners and practitioners working with people who are motivated to change their health-related behaviour.

What action should they take?

- Provide interventions that:
  - Aim to make it feasible for people to change their behaviour
  - Enhance and develop people's skills to help them make positive changes
  - Help and support individuals to plan in advance for situations where they might feel tempted to revert to behaviours which could damage their heath.

- Focus on the feasibility of change and its benefits.

Recommendation 6

Who should take action?
Policy-makers, commissioners and employers of practitioners whose work impacts on people's health-related behaviour or who wish to change health-related behaviour.

What action should they take?

- Ensure everyone who is involved in delivering interventions to change people's health-related behaviour receives appropriate training.

- Ensure appropriately-trained professionals plan, deliver, implement and evaluate interventions and programmes aimed at changing people's health-related behaviours.

Recommendation 7

Who should take action?
Policy-makers and commissioners whose work impacts on people's health-related behaviour.

What action should they take?

- Gather information about the context, needs and behaviours of the target population(s).

- Use this knowledge to deliver tailored, population-level policies, interventions and programmes aimed at changing health-related behaviours. These include:

  - Fiscal and legislative interventions, for example, taxation and age restrictions on certain behaviours
  - National and local advertising and mass media campaigns
  - Point-of-sale promotions and interventions.

- Ensure that population-level interventions are sustained over time, and are consistent with messages and interventions delivered at the individual and community-level.