National Institute for Health and Clinical Excellence

Centre for Public Health

Review Decisions

Review of the public health guidance on

Behaviour change: the principles for effective interventions (PH6)

1 Background information

Guidance issue date: October 2007

3 year review date: 2010

3 year review date: 2014

The current guidance can be found at: http://www.nice.org.uk/guidance/ph6

2 Recommendation

The whole of PH6 should be reviewed and refreshed for terminology and contextual issues.

New guidance should be developed to partially update PH6 on effective and cost-effective *population-level* interventions for health-related behaviour change. This should include multi-level interventions that include a population-level component. The approach should be guided by the Rose principle[3]; i.e. focus on activities and interventions which reduce the risk levels in the population as a whole, shifting the whole health gradient in the direction of health improvement and being mindful of the impact on the overall inequalities slope of the gradient. This should include a review of the principle in PH6 about 'selecting interventions and programmes aimed at populations' to determine whether it still stands or requires re-drafting.

3 Process for updating guidance

Public health guidance is reviewed at 3-yearly intervals after publication to determine whether all or part of it should be updated. The process for updating is as follows:

- NICE convenes an expert group to consider whether any new evidence or significant changes in policy and practice would be likely to lead to substantively different recommendations. The expert group consisted of members from the original committee (including co-optees) that developed the original guidance (PH6), and members from the committee that developed behaviour change: individual approaches guidance (PH49). It also included policy leads from the Cabinet Office and Public Health England, and a key expert on behaviour change from the University of Cambridge, currently leading a DH-funded programme of work in the area.

- NICE consults with stakeholders on its proposal for updating the guidance.

- NICE may amend its proposal, in light of feedback from stakeholder consultation.

- NICE adds any guidance update to the work programme.

4 Consideration of the evidence and practice

A meeting was held on 6th May 2014 to discuss with experts whether there is a need to further update the Public Health Guidance on Behaviour Change. The expert group consisted of members from the original committee (including co-optees) that developed the original guidance (PH6), and members from the committee that developed behaviour change: individual approaches guidance (PH49). It also included policy leads from the Cabinet Office and Public Health England, and a key expert on behaviour change from the University of Cambridge, currently leading a DH-funded programme of work in the area. Written views were also sought from committee members from PH6 and PH49 who were unable to attend the meeting. The expert group was asked to consider:

- The need to update the guidance, in whole or in part, based on evidence published since 2007

- The need to update the language / terminology in the guidance, as a result of system and structural changes since 2007
- The relevance of the guidance for public health practice today, and the needs of the public health service for updated guidance

Policy context

The group discussed changes in the public health system since 2007, which have been extensive. The transfer of the majority of public health functions into local government in 2013 has created a new audience for the guidance, with a heightened emphasis on efficiency and return on investment. They noted the importance of local government in influencing population health, highlighting that the guidance needs to speak to these new audiences. They also emphasised the importance of translation of evidence into actionable recommendations.

The group noted that the NICE local government briefing on PH6, published in 2013, configures the principles for a local government audience and includes an action plan – which may help to address some of the implementation feedback summarised below. They also noted that PH49 built on the principles contained in the original guidance, using new evidence and making recommendations on effective and cost-effective approaches for working with individuals to support and maintain behaviour change.

Since the publication of PH6, the study and application of behaviour change techniques such as choice architecture and behavioural economics have gained considerable profile across government. In 2010 the coalition government established the Behavioural Insights Team within the Cabinet Office, comprising of academics, policy and marketing experts charged with developing evidence-based initiatives that would 'encourage and support people to make better choices for themselves'[1]. This team was partially privatised in early 2014, and ownership is now shared between Government, the innovation-focused charity Nesta, and employees of the team.

[1] https://www.gov.uk/government/organisations/behavioural-insights-team

Both the Department of Health and Public Health England also include teams focusing on the application of behaviour change techniques to their areas of responsibility, and these common strands of work emphasise the extent to which this area of behavioural science is now influencing the design and delivery of health-related (and other) policy at population level.

Evidence

The group noted that there was new evidence since 2007 that would warrant a partial update of PH6 looking at the effectiveness of population-level behaviour change interventions that address the health of the whole population (i.e. from birth onwards, including all sectors of society). The group was clear that it would not be helpful to look further at evidence relating to individual-level interventions as this had been addressed in PH49.

New and emerging evidence was discussed in several areas, which have been grouped according to different environments that have an impact on behaviour at a population level:

Policy - The group noted that the evidence base for policy interventions in general has increased considerably; and that the methods for evaluating policy interventions have improved - for example, following the publication in 2011 of the Medical Research Council's guidance on "Using natural experiments to evaluate population health interventions". They noted that there are now more unifying frameworks within which we can evaluate and make sense of disparate data across many domains. One that is being used quite widely across the UK Government is the Behaviour Change Wheel – this allows both 'retrofitting' of current policies to identify what they consist of, and what they do not, and systematically identifying evidence for the effectiveness of seven policy categories and nine intervention functions according to target behaviours.

- Economic environment: there is recent evidence concerning how changes in pricing through minimum pricing and/or taxes of alcohol, high sugar/high fat foods, and tobacco products influence behaviour. In particular there is evidence from outside of the UK relating to tax on sugar sweetened beverages reducing the obesity rate; and evidence on the impact of taxes and food subsidies on diet from a scoping review of

the economic environment undertaken by the Behaviour and Health Research Unit (BHRU), Cambridge University.

- social environments including the digital environment: the group identified new evidence in the area of social network analysis and highlighted that the original guidance did not look at digital social networks, and the way communities integrate, areas for which there is emerging evidence.

- physical environments (macro- and micro-environment): There is a growing body of evidence supporting the modification of the physical environment as a means of encouraging physical activity. Some examples of this include structural adjustments to buildings to facilitate more physical activity and availability of sidewalks and bike lanes.

Choice architecture interventions[2]: A synthesis of existing evidence on the effectiveness of choice architecture interventions is currently being undertaken by the BHRU. The evidence was identified by a scoping review which found that the vast majority of evidence concerns interventions aiming to improve diet, but there are also studies of interventions on improving physical activity (primarily targeting stair-use), reducing alcohol consumption and smoking. Once findings of this synthesis are available, these could be used to inform the update.

The National institute for health research (NIHR) is also in the process of commissioning primary research to address 'What are the effective and cost-effective choice architecture interventions to promote healthier behaviours or reduce health risk behaviours for smoking, alcohol, food intake and physical activity?' but the findings of this research will not emerge for several years.

- Mass media and social marketing: There are studies evaluating the effectiveness of mass media and social marketing campaigns aiming to change behaviour which would provide details of the design, content, duration and delivery modes of

[2] Interventions which change the context in which someone will make a decision in order to influence how they act. For example, placing healthier snacks closer to a shop checkout and putting sugary and high-fat options out of reach may influence people to make a healthier choice because it is more accessible. Behaviour change approaches based on choice architecture are also referred to as 'nudge' or 'nudging' interventions (Thaler and Sunstein 2008).

campaigns - details of which were not covered in the original behaviour change guidance.

5 Implementation and post publication feedback

The enquiry handling team reported 38 enquiries in relation to the guidance. The majority were classified as 'standard', requesting information on where to access guidance, website issues, hard copies, and so on. Remaining enquiries ranged from requesting information on planning, implementation and audit tools to specific questions about the evidence base.

Feedback from NICE Implementation consultants was collated following routine meetings with local providers of public health programmes. There were 18 comments relating to PH6. Seven people reported using the guidance during the development of local programmes, policies or strategies. One person stated that a cultural change was required for clinicians to see the guidance as being relevant, while another thought that the guidance had brought a needed cultural change to the area of service improvement. There were several comments concerning the length of the guidance and ease of use: the guidance document was said to be too long and two respondents felt that this could be an issue for local authorities and councillors. One person suggested that the guidance document itself was difficult to follow and another that there were too many "bitty" recommendations. Two people reported that assessing uptake of the guidance was difficult to determine due to a lack of measurable outcomes.

6 Equality and diversity considerations

There is evidence to indicate that the guidance does comply with anti-discrimination and equalities legislation.

7 Stakeholder consultation

The proposal put to stakeholders was that the principles in PH6 should be reviewed and refreshed for terminology and contextual issues. In addition, it was proposed that new guidance is developed to partially update PH6 on effective and cost-effective population-level interventions for health-related behaviour change. The

approach will be guided by the Rose principle[3]; i.e. there will be a focus on activities and interventions which reduce the risk levels in the population as a whole, shifting the whole health gradient in the direction of health improvement and being mindful of the impact on the overall inequalities slope of the gradient. This will include a review of the principle in PH6 about 'selecting interventions and programmes aimed at populations' to determine whether it still stands or requires re-drafting.

Registered stakeholders were invited to comment on the proposal during a 2 week consultation in June/July 2014. There were 15 responses to the consultation, including from the Department of Health, Public Health England, a local Drugs and Alcohol Action Team, one University, four voluntary sector organisations and three Royal Colleges. None of the stakeholders disagreed with the review proposal recommendations. However, three stakeholders did not respond to the recommendations set out in the review proposal, rather they provided feedback on the original PH6 guidance document; and two stakeholders (the Department of Health and The Royal College of Nursing) stated that they had no comments to make.

Six stakeholder organisations stated that they supported the proposal to review and refresh the principles in PH6 for terminology and contextual issues. The remaining stakeholders did not provide any comments on this. One stakeholder noted that other sections of PH6 were out of date such as the 'Implementation' section which references obsolete policies.

Nine stakeholders expressed support for partially updating PH6, with the focus on effective and cost-effective population-level interventions for health-related behaviour change. The remaining stakeholders did not disagree with the proposal. Several stakeholders highlighted that behaviour change interventions were more likely to be effective and lead to sustained behaviour change if there was a combination of individual, community and population-level interventions. They were concerned that the focus on population-level interventions would not include relevant evidence on

[3] Rose, G. (2008) *Rose's Strategy of Preventive Medicine, The Complete Original Text,* commentary by Khaw, K-T. & Marmot, M. Oxford: Oxford University Press.

the effectiveness of multi-level interventions which include a population-level component.

8 Conclusion

Stakeholders largely confirmed the view of the expert group that the principles in PH6 are still relevant and useful, however the language and terminology used in the whole guidance needs refreshing to reflect the new public health service.

Stakeholders were also in agreement that the new evidence published since 2007 on population-level interventions, including fiscal measures, financial incentives, physical and social environment-based interventions, choice architecture and policy would allow the development of new, more detailed guidance on the effectiveness and cost-effectiveness of population-based intervention for health related behaviour change. The importance of including evidence on multi-level interventions that include a population-level component was also noted.

Mike Kelly, CPH Director

Catherine Swann, CPH Associate Director

Charlotte Haynes, CPH Analyst

31st July 2014