

# National Institute for Health and Clinical Excellence

## PUBLIC HEALTH PROGRAMME GUIDANCE – CARDIOVASCULAR DISEASE

Consultation on the Draft Scope from  
Wednesday 23<sup>rd</sup> April – Thursday 22<sup>nd</sup> May 2008

Comments on the Draft Scope to be submitted  
no later than 5pm on Thursday 22nd May 2008

### Stakeholder Comments

Please use this form for submitting your comments to the Institute.

1. Please put each new comment in a new row.
2. Please insert the **section number** in the 1<sup>st</sup> column. If your comment relates to the document as a whole, please put '**general**' in this column

<b>Name:</b>	<b>Cardiovascular Health Working Group</b>
<b>Organisation:</b>	<b>Faculty of Public Health</b>
<b>Section number</b>  Indicate <b>section number</b> or ' <b>general</b> ' if your comment relates to the whole document	<b>Comments</b>  Please insert each new comment in a new row.
General	The Faculty of Public Health welcomes this planned Programme Guidance scoping document. It is extremely important that a population approach is taken to reducing cardiovascular risk. It is the most cost-effective approach and can yield the greatest returns. It is important to acknowledge that many, perhaps most, of the factors determining people's risk of developing or dying from cardiovascular disease lie outside the health services and need to be tackled by society-wide changes to the environment in which individuals live, the range of options available to them, and what decisions they therefore make. Much has been written about 'the obesogenic environment' in which we now live and we look forward to reading the NICE guidance in March 2010 on effective steps to tackle this.
General	There needs to be a clear distinction between "evidence of no effect" and "no evidence".
General	Where there is no evidence of the effects of interventions, we would ask NICE to examine the evidence on factors that facilitate or impede healthier lifestyles (such as transport policies that act as barriers to physically active transport) so that when policy decisions are taken by local, regional or even national government in such areas, what is known can be used, even if that information is incomplete. Recognising that there will not always be experimental evidence we recommend that NICE adopts a criteria to seek out the best available evidence.

Please add extra rows as needed

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General	Please cite primary sources even in the introduction. If there is no time to go back to the primary sources, perhaps you could reference it as (eg Health Survey for England 2005, cited by Allender et al 2007)
General	We understand that the brief is as given to NICE by the Department of Health. We are not concerned that it is 'limited' to cardiovascular disease and excludes cancers because several primary prevention interventions that reduce cardiovascular risk will also impact on many cancers, albeit with a much longer timescale. This is particularly the case where they share major risk factors (such as tobacco use, physical activity, diet, obesity, high alcohol consumption). Similarly, we assume that interventions that help reduce or prevent obesity, diabetes, and metabolic syndrome would be included because of their impact on cardiovascular risk.
3 b)	Whilst we agree that CVD risk is higher in <i>some</i> South Asian groups, it is important to acknowledge that this is a heterogeneous group. There is much variation in risk of obesity, diet and physical activity levels between for example, Bangladeshi compared with Indian communities. Given that "South Asians" comprise a large and growing minority population in the UK, it would be useful to make such distinctions where possible.
4.1	We agree that it should focus on local, regional and national populations and not on individuals with or at high risk of developing CVD. Population-wide changes, such as making a healthier diet or physically active transport easier and reducing public exposure to tobacco smoke, should also benefit these groups. It is important that all ages are included in this guidance, and where appropriate, a life course approach is adopted. However, where an intervention has been tried only on one age group or been found to be effective only for certain age groups, it should not be excluded on the grounds of not being tested or effective for all ages, provided the age limits are specified (and any adverse effects on other age groups mentioned, if applicable).

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4.1	We understand that this is population-level guidance but there is good evidence that primary prevention measures at the individual level can increase inequalities while improving overall population health.
	It is therefore very important that when reviewing the evidence, the reviewers also examine any evidence on differential effects of interventions and the potential impact of interventions on inequalities in cardiovascular disease, risk factors, and the determinants of inequalities.
	Inequalities are often increased by health education measures and health screening interventions, which differentially affect the more affluent although they are at lower risk. This happened, for example, with health education measures stemming from the RCP report on the health effects of smoking in the 1960s and has been found in many screening programmes. Population level interventions that require individuals to do something actively tend to increase inequalities, while those that make healthier choices easier (eg making healthier foods cheaper or more convenient, or smoke-free legislation) may well reduce inequalities.
	We understand it may be outside the scope of the planned guidance to explore interventions targeted at specific sub-groups. However, we recommend that the guidance address where population level interventions can or should be targeted specifically at areas with higher prevalence of cardiovascular risk or prioritised to cover those areas first, to reduce the risk of area-wide implementation increasing inequalities. For example, if there were a recommendation to improve street lighting, introduce home zones, have wider clearer pavements, or provide traffic-free walking and cycling routes, these cannot be implemented everywhere at once. It may therefore be sensible to provide them first in more deprived areas, as has been done in The Dingles areas in Bristol.
	If it is outside the scope of the planned guidance to explore targeted interventions, we recommend that additional programme guidance for targeted population level primary prevention of CVD be developed.

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4.2.1 / Key Question 1	We are concerned that this programme guidance is being limited in such a way as to exclude many effective interventions. If other guidance had covered population level interventions for primary prevention for all the major cardiovascular risk factors, particularly tobacco use, physical activity, diet, obesity, hypertension, psychosocial stress, diabetes, and high alcohol consumption, then we could understand limiting this guidance to multiple risk factor interventions. However, we are not convinced this is the case.
	We are very concerned about the emphasis on multiple risk factor intervention.
	We are not aware of any previous guidance that examines the effectiveness of programmes of multiple interventions for a single risk factor, rather than examining the individual effects of each intervention. For example, it is a widely held belief in the field of tobacco control that a broad raft of measures act synergistically and are more effective than single interventions. It would be unfortunate to omit such interventions on the grounds that they tackle only a single but important risk factor.
	What constitutes a single risk factor, so that two can be identified? For example, if obesity or diabetes were the sole outcome of interest it might be considered a single risk factor but if the identical interventions were tested with physical activity and diet as outcomes, would this become multiple risk factor interventions? And what about interventions designed to reduce fat intake and increase fruit and vegetable consumption?
	Limiting the scope to “multiple risk factor” approaches, would also exclude a number of effective community interventions focussed on one factor, such as the trans-fat ban in New York, or interventions to influence social capital, the cooking oil legislation in Mauritius, the dietary salt reduction in Finland, or local smokefree legislation.
	Furthermore, evidence of population interventions to reduce psychosocial stress with cardiovascular disease are likely to be particularly limited. By including them only if they are part of multiple risk factor interventions would be too restrictive.
4.2.1 a)	We agree that the examples of the approaches outlined (e.g. education, fiscal change) are important for population level interventions. We assume environmental change would include school level and workplace interventions, as well as community interventions (e.g. the Minnesota Heart Health Programme, or the Swedish, Dutch and other community intervention programmes)

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4.2.2 a)	<p>We agree that this guidance should not cover individual-level secondary prevention and interventions aimed only at those at higher risk of developing CVD, as these are covered in other guidance.</p> <p>In other words, this PDG can exclude interventions involving tablets.</p> <p>However, where there are population level interventions that are effective, they should not be excluded just because the distinction between primary and secondary prevention cannot be disaggregated. It is likely that most successful population level interventions (eg adjusting tax on food to make healthier foods cheaper than unhealthy food) would be beneficial in reducing CVD among both those who already have disease or are at high risk, as well as among those who are disease free eg because they are too young).</p> <p>These terms are in any case difficult to define. Is it primary or secondary prevention to prevent the development of diabetes in people with impaired glucose tolerance or abdominal obesity or preventing CVD in people with diabetes or hypertension?</p>
4.2.2 b)	<p>We agree that this guidance should not cover screening not accompanied by interventions to modify the findings.</p>
4.3 Question 1	<p>The CVD risk factors mentioned are important, but perhaps should be better defined to help clarification. We assume that “smoking” includes both active and passive smoking, and “diabetes” should also include metabolic syndrome. It would be useful if “poor diet” was also clarified and categorised (e.g. high saturated fat, trans fat, high salt etc)</p>

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