NICE National Institute for Health and Care Excellence

Surveillance proposal consultation document 2018

Surveillance background

This 2018 surveillance review has taken into account 2 NICE guidelines on the theme of cardiovascular disease (CVD) prevention:

- Cardiovascular disease: identifying and supporting people most at risk of dying early NICE guideline PH15 (2008)
- Cardiovascular disease prevention NICE guideline PH25 (2010).

Surveillance decision

Cardiovascular disease: identifying and supporting people most at risk of dying early (PH15)

- We propose to not update the NICE guideline on Cardiovascular disease: identifying and supporting people most at risk of dying early (PH15) at this time.

Cardiovascular disease prevention (PH25)

- We propose to not update the NICE guideline on Cardiovascular disease prevention (PH25) at this time.

Note: We did not consider recommendations 1 to 12 of NICE guideline PH25 within this review because the activities they cover are beyond the remit of NICE.

It is acknowledged that the structures and responsibilities of regional and local partnerships, local government and the NHS has changed considerably since the PH25 guideline published in 2010. Recommendations in both guidelines will be will be refreshed to bring them up to date and to address editorial or factual corrections that were identified. Details are included in appendix A1: NICE guideline PH15 and appendix A2: NICE guideline PH25.

Overview of 2018 surveillance methods

NICE's surveillance team checked whether recommendations in the following guidelines remain up to date:

- Cardiovascular disease: identifying and supporting people most at risk of dying early (NICE guideline PH15)
- Cardiovascular disease prevention (NICE guideline PH25)

The surveillance process consisted of:

- Initial feedback from topic experts and Public Health England (PHE) via a questionnaire.

- Mapping of existing NICE guidelines on topics related to cardiovascular disease prevention to identify areas of overlap.
- Literature searches to identify evidence relevant to PH25.
- Assessment of new evidence against current recommendations.
- Deciding whether or not to update sections of the guideline, or the whole guideline.
- Consultation on the decision with stakeholders (this document)

After consultation on the decision we will consider the comments received and make any necessary changes to the decision. We will then publish the final surveillance report containing the decision, the summary of the evidence used to reach the decision, and responses to comments received in consultation.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Evidence considered in surveillance

Search and selection strategy

We did not undertake a formal evidence review for the guidelines in the current surveillance review because relevant, new evidence would be considered through surveillance reviews of existing NICE guidelines that cover the main risk factors linked with cardiovascular disease.

We conducted focused searches on the following areas where topic experts suggested there may be new evidence related to primary prevention of CVD: 1) workplace interventions, and 2) social media approaches. We also searched for new evidence on: 3) UK local CVD prevention interventions (interventions at sub-national level).

In addition, we undertook a rapid review to identify UK evidence related health check programmes for CVD prevention.

See in appendix A1: NICE guideline PH15 and appendix A2: NICE guideline PH25 below for details of all evidence considered, with references.

Ongoing research

We checked for relevant ongoing research; of the ongoing studies identified, 3 studies related to NHS Health Check and have the potential to change recommendations; therefore we plan to check the publication status regularly, and evaluate the impact of the results on current recommendations as quickly as possible.

Advice considered in surveillance

Views of topic experts

We considered the views of topic experts.

For these surveillance reviews topic experts completed a questionnaire about developments in evidence, policy and services related to the guideline.

The NICE surveillance team would like to thank the topic experts who participated in this process.

Views of stakeholders

We obtain the views of stakeholders on surveillance decisions through consultation.

See ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual for more details on our consultation processes.

Other sources of information

We also consulted topic experts from CVD programmes at PHE and NHS England.

Equalities

No equalities issues were identified during the surveillance process.

Appendix A1: Summary of evidence from surveillance

2018 surveillance of Cardiovascular disease: identifying and supporting people most at risk of dying early (2008) NICE guideline PH15

Intelligence gathering

We checked any legislation, policy, or other guidance documents that had been issued or updated since NICE guideline PH15 was published.

The initial intelligence gathering identified the PHE/NMS 'RightCare CVD Prevention Pathway' which covers risk conditions for cardiovascular disease prevention: blood pressure, hypertension, atrial fibrillation (AF), high cholesterol, diabetes, pre-diabetes and chronic kidney disease (CKD). There are a number of NICE guidelines for each risk condition specified in 'RightCare CVD Prevention pathway' that recommend interventions for secondary prevention of cardiovascular disease. This includes:

- Hypertension (Hypertension in adults: diagnosis and management (CG127); Hypertension in pregnancy: diagnosis and management (CG107)), promoting lifestyle interventions and antihypertensive drug treatment,
- Atrial fibrillation (Atrial fibrillation: management (CG180)) promoting anticoagulants.
- Familial hypercholesterolemia (Familial hypercholesterolaemia: identification and management (CG71))
- Chronic kidney disease (Chronic kidney disease in adults: assessment and management (CG182))
- A set of diabetes guidelines (NICE pathways: Diabetes overview) covering both type 1 and type 2 diabetes and associated cardiovascular risk.

The initial intelligence gathering also identified the recent PHE publication an 'Action Plan for cardiovascular disease prevention 2017-18'. The action plan describes modifiable behavioural, social and environmental factors that impact on CVD. There is a range of NICE guidelines covering specific behavioural risk factors for CVD that supports the initiatives that PHE are promoting and fit the remit of NICE guideline PH15. These guidelines are listed in the mapping exercise below. In addition, the following guideline and NICE pathway are relevant:

- Cardiovascular disease: risk assessment and reduction including lipid modification NICE guideline CG181.
- NICE guidelines covering specific behavioural risk factors for CVD, including alcohol, physical activity, weight management, diet and smoking. These are detailed in the NICE pathway 'Lifestyle changes for preventing cardiovascular disease'.

Views of topic experts

Topic experts recommended that the PH15 NICE guideline could be expanded to include secondary prevention of cardiovascular disease for the risk conditions outlined in the PHE/NMS 'RightCare CVD Prevention Pathway'. As discussed above, NICE has published a number of guidelines that recommend interventions for secondary prevention of cardiovascular disease; for example, Atrial fibrillation: management (CG180).

Experts also emphasised the importance of the range of primary prevention activities, and the focus should be broader than people who smoke and are eligible for statins. We conducted a mapping exercise (see below) to identify the range of NICE guidelines which cover the key behavioural risk factors for CVD and whether they identify adults at risk and promote the uptake of interventions.

To address expert's comments, it proposed that Section 7 of the guideline 'related NICE guidance' will be updated to include reference to NICE guidelines for primary and secondary prevention of CVD.

One expert noted that social prescribing is not covered in the guideline. Relevant guidelines for primary prevention activities may provide recommendations on related support activities in the future as the evidence base for social prescribing develops.

Experts indicated that NHS Health Check is relevant to this guideline topic. The NHS Health Check is a programme for adults aged 40-74 and is designed to identify people who are at risk of developing conditions, including those related to CVD. This area was not covered in the guideline - which published in 2008, before the introduction of NHS Health Check - but it is relevant to recommendation 1: identifying adults at risk. It is proposed that a cross-reference to NHS Health Check is added from recommendation 1.

The NHS Health Check is cross-referenced from NICE guideline PH25 and is discussed further in appendix A2 .

See Editorial and factual corrections below for further details on proposed changes to the guideline.

Mapping of existing NICE guidelines on topics related to primary prevention of cardiovascular disease to identify areas of overlap

A mapping exercise was conducted to identify relevant guidelines published by NICE which cover behavioural risk factors for CVD and that fit the remit for PH15. In particular, the mapping aimed to establish whether existing guidelines for CVD behavioural risk factors cover the identification of people at risk and promote the uptake of related interventions. Details of the mapping can be found in Table 1. The mapping confirms the relevance of various NICE guidelines to the remit of PH15 and those which address the identification and support of people most at risk of CVD.

NICE guidelines listed in the following table can be found at:
https://www.nice.org.uk/guidance/published

Table 1. Overview of NICE guidelines for primary prevention of CVD risk factors

Risk Factor	NICE guidelines	Description	Areas covered by recommendations:
Diet & Excess weight	Obesity prevention (NICE guideline CG43)	The guideline makes recommendations based on settings e.g. early years, NHS, local authority, workplaces on obesity prevention.	identification of adults at risk promote uptake of interventions
Diet & Excess weight	Obesity working with local communities (NICE guideline PH42)	The guideline covers how local communities, with support from local organisations and networks, can help prevent people from becoming overweight or obese or help them lose	promote uptake of interventions

Risk Factor	NICE guidelines	Description	Areas covered by recommendations:
		weight. It also aims to support sustainable and community-wide action to achieve this.	
Diet & Excess weight	Weight management: lifestyle services for overweight or obese adults (NICE guideline PH53)	The guideline covers multi-component lifestyle weight management services including programmes, courses, clubs or groups provided by the public, private and voluntary sector. The aim is to help people lose weight and become more physically active to reduce the risk of diseases associated with obesity. This includes coronary heart disease, stroke, type 2 diabetes and various cancers.	identification of adults at risk promote uptake of interventions
Diet & Excess weight	Preventing excess weight gain (NICE guideline NG7)	The guideline covers behaviours such as diet and physical activity to help children (after weaning), young people and adults maintain a healthy weight or help prevent excess weight gain. The aim is to prevent a range of diseases and conditions including cardiovascular disease and type 2 diabetes and improve mental wellbeing.	promote uptake of interventions
Diet & Excess weight	Obesity: identification, assessment and management (NICE guideline CG189)	The guideline covers identifying, assessing and managing obesity in children (aged 2 years and over), young people and adults. It aims to improve the use of bariatric surgery and very-low-calorie diets to help people who are obese to reduce their weight.	identification of adults at risk promote uptake of interventions
Physical activity	Physical activity and the environment (NICE guideline NG90)	The guideline covers how to improve the physical environment to encourage and support physical activity. The aim is to increase the general population's physical activity levels.	promote uptake of interventions

Risk Factor	NICE guidelines	Description	Areas covered by recommendations:
Physical activity	Physical activity in the workplace (NICE guideline PH13)	The guideline covers how to encourage employees to be physically active.	promote uptake of interventions
Physical activity	Physical activity: brief advice for adults in primary care (NICE guideline PH44)	The guideline covers providing brief advice on physical activity to adults in primary care. It aims to improve health and wellbeing by raising awareness of the importance of physical activity and encouraging people to increase or maintain their activity level.	identification of adults at risk promote uptake of interventions
Physical activity	Physical activity: walking and cycling (NICE guideline PH41)	The guideline covers encouraging people to increase the amount they walk or cycle for travel or recreation purposes.	promote uptake of interventions
Physical activity	Physical activity: exercise referral schemes (NICE guideline PH54)	The guideline covers exercise referral schemes for people aged 19 and older, in particular, those who are inactive or sedentary and when it may be appropriate to refer people to exercise referral schemes.	identification of adults at risk promote uptake of interventions
Smoking	Smoking: workplace interventions (NICE guideline PH5)	The guideline covers how employers can encourage and support employees to stop smoking	promote uptake of interventions
Smoking	Stop smoking interventions and services (NICE guideline NG92)	This guideline covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12.	identification of adults at risk promote uptake of interventions
Smoking	Smoking: preventing uptake in children and young people (NICE guideline PH14)	The guideline covers ant-smoking mass media and measures to prevent tobacco being sold to children and young people.	promote uptake of interventions

Risk Factor	NICE guidelines	Description	Areas covered by recommendations:
Smoking	Smoking: stopping in pregnancy and after childbirth (NICE guideline PH26)	The guideline covers support to help women stop smoking during pregnancy and in the first year after childbirth. It includes identifying women who need help to quit, referring them to stop smoking services and providing intensive and ongoing support to help them stop. The guideline also advises how to tailor services for women from disadvantaged groups in which smoking rates are high.	identification of adults at risk promote uptake of interventions
Smoking	Smoking: harm reduction (NICE guideline PH45)	The guideline covers interventions to reduce harm from smoking aiming to help people: who may not be able (or do not want) to stop smoking in one step, who may want to stop smoking without giving up nicotine and those who may not be ready to stop smoking but want to reduce the amount they smoke.	promote uptake of interventions
Smoking	Smoking: acute, maternity and mental health services (NICE guideline PH48)	The guideline covers helping people to stop smoking in acute, maternity and mental health services. It promotes smokefree policies and services and recommends effective ways to help people stop smoking or to abstain from smoking while using or working in secondary care settings.	identification of adults at risk promote uptake of interventions
Harmful drinking	Alcohol-use disorders: prevention (NICE guideline PH24)	The guideline covers alcohol problems among people over 10. It aims to prevent and identify such problems as early as possible using a mix of policy and practice.	identification of adults at risk promote uptake of interventions
Harmful drinking	Alcohol-use disorders: diagnosis, assessment and management of harmful drinking	The guideline covers identifying, assessing and managing alcohol-use disorders (harmful drinking and alcohol dependence) in adults and young people aged	identification of adults at risk promote uptake of interventions

Risk Factor	NICE guidelines	Description	Areas covered by recommendations:
	and alcohol dependence (NICE guideline CG115)	10–17 years. It aims to reduce harms from alcohol by improving assessment and setting goals for reducing alcohol consumption.	

Editorial and factual corrections identified during surveillance (PH15)

During surveillance editorial or factual corrections were identified.

- General corrections:
  - PCTs no longer exist and reference to PCTs in the recommendations will be removed or replaced with a suitable alternative; where appropriate, a generic reference will be made to Health and wellbeing boards, commissioners and directors of public health.
- Recommendations:
  - Introduction section; the following text will be updated as the reference is no longer available: 'According to NICE guidance, if someone has a 20% or higher risk of a first cardiovascular event in the next 10 years they are deemed at high risk of CVD (see NICE clinical guideline 67 on lipid modification)'. It will be replaced with the following text: 'According to NICE guidance, people are deemed to be at high risk if their estimated 10-year risk of CVD is 10% or more, and they should be prioritised for a full formal risk assessment (NICE guideline CG181 Cardiovascular disease: risk assessment and reduction including lipid modification).
  - Recommendation 1: The following bullet point will be added: 'Primary care professionals should use a range of methods to identify adults who are disadvantaged and at high risk of premature death from CVD. These include: primary care appointments (for example, during routine visits, screening and planned NHS Health Check)'.
  - Recommendation 2 and 5: Reference is made to 'Behaviour change at population, community and individual levels [NICE public health guidance 6]'. This guideline has been superseded and will be replaced with a cross-reference to both Behaviour change: general approaches (PH6) and Behaviour change: individual approaches (PH49).
  - Recommendations 4 and 5: Reference is made to 'Community engagement to improve health [NICE public health guidance 9]'. This guideline has been updated and the link will be replaced with a cross-reference to Community engagement: improving health and wellbeing and reducing health inequalities (NG44).
  - Recommendation 5 refers to 'Standard for training in smoking cessation treatments'. This link is broken and will be removed.
  - The footnote from Recommendation 2 will be replaced and a reference made to NHS Health Check audit.
- Section 7 'Related NICE guidance' will be updated to include information about NICE guidelines which cover both primary and secondary prevention activities for CVD.

Appendix A2: Summary of evidence from surveillance

2018 surveillance of Cardiovascular disease prevention (2010) NICE guideline PH25

Summary of evidence from surveillance

Studies identified in searches are summarised from the information presented in their abstracts. Full texts are consulted in specific circumstances, for example if the full text is necessary to make a definitive statement about the impact of the study on current recommendations.

Feedback from topic experts who advised us on the approach to this surveillance review was considered alongside the evidence to reach a final decision on the need to update each section of the guideline.

Regional CVD prevention programmes

Recommendation 13: Regional CVD prevention programmes - programme development

Recommendation 14: Regional CVD prevention programmes – preparation

Recommendation 15: Regional CVD prevention programmes – programme development

Recommendation 16: Regional CVD prevention programmes – resources

Recommendation 17: Regional CVD prevention programmes – leadership

Recommendation 18: Regional CVD prevention programmes – evaluation

The 6 recommendations have been considered together because they relate to regional and local CVD prevention programmes.

2018 surveillance approach

For 2018 surveillance, 2 searches were conducted:

- We undertook a focused search for UK local CVD prevention interventions (interventions at sub-national level). Evidence was searched from 1 January 2010 – 21 November 2017 across 3 databases: Medline, Medline-in-process and Medline e-publications. Based on the PH25 scope, we looked for studies of interventions that addressed **two or more** CVD risk factors. The standard surveillance review process of using RCT and systematic review selection criteria was used for this search. This research yielded no studies that were eligible for inclusion.
- We also undertook a rapid review to identify UK evidence related health check programmes for CVD prevention. Evidence was searched from 1 January 1996 – 21 November 2017 across 3 databases: Medline, Medline-in-process and Medline e-publications. Searches identified 56 references; 32 references appeared in the NHS Health Check Programme rapid evidence synthesis

and 9 were not related to CVD. From the remaining 15 references, 9 studies were related to NHS health check programme (uptake interventions for under-served groups (n=1), identifying people at risk (n=1), evaluation of NHS health check (n=6), patients experience (n=1)), 3 studies were about other interventions for identifying people at risk (online tool, supermarket screening, risk score) and 3 studies were related to CVD risk factors.

Surveillance decision

These recommendations should not be updated.

The following editorial corrections are needed:

- General corrections:
  - PCTs and Strategic Health Authorities no longer exist and references will be removed or replaced with a suitable alternative; where appropriate, a generic reference will be made to Health and wellbeing boards, commissioners and directors of public health. Where there is reference to combined PCT and local authority areas or regions reference will be made to sustainability and transformation partnerships (STPs). In addition, references to city region partnerships, local strategic partnerships, government regional offices and local area agreements will be removed.
- Recommendations:
  - Recommendation 15 - The following text will be removed as it is out of date: 'Ensure the programme helps address local area agreement targets and acts as a local incentive for world class commissioning in the NHS.'
  - Recommendation 15 – As the list cross–references to NICE guidelines does not cover the current breadth of published guidelines it will be replaced with: "When developing CVD programmes, take account of relevant recommendations across NICE guidelines within the following NICE pathway 'Lifestyle changes for preventing cardiovascular disease'.
  - Recommendation 18 - There is a cross- reference to 'Behaviour change' [NICE public health guidance 6]. This link will be replaced with a cross-reference to the updated Behaviour change: general approaches [NICE guideline PH6].

Recommendations 13 to 18.

2018 surveillance summary

Evidence was identified on the health checks for CVD prevention, including the NHS Health Check programme:

One systematic review and 5 observational studies were identified that reported on health check programmes:

A systematic review(1) of 20 studies (qualitative and quantitative data) assessed the experiences of patients attending NHS Health Check in England. It concluded that there were consistently high levels of reported satisfaction in surveys, with over 80% feeling that they had benefited from an NHS Health Check.

A cross sectional observational study(2) of socio-demographic data of 43,177 health check attendees across 38 local authorities on evaluation of community-based outreach providers (in delivering NHS Health Check programme) was identified. Community outreach providers operated on evenings and weekends as well as during regular business hours in venues accessible to the general

public. The findings indicated that community-based outreach providers effectively reach under-served groups by delivering preventive CVD services to younger, more deprived populations, and a representative proportion of ethnic minority groups.

An observational study(3) on implementation of NHS Health Check programme over 4 years (April 2009--March 2013) at 655 general practices across England reported that the programme coverage was lower than expected, but showed year-on-year improvement (of 1.68 million people eligible for an NHS Health Check, 214,295 attended in the period 2009-12).

A cohort study(4) at 5 general practices (n=4,855) in England investigated the effective methods of invitation to NHS Health Check programme. It found telephone/verbal invitations were associated with higher uptake than postal invitations.

An observational study(5) evaluated the NHS Health Check programme, based on analysis of patient electronic health records, from 2010 to 2013, in England (n=140,356). It found slight reductions in the risk factor values (hypertension, total cholesterol) in the minority of participants at 15 months follow up.

A pilot RCT(6) assessed the opportunistic health checks in a retail environment over an 8 week period (n=1024). The study was carried out on 8 consecutive Saturday clinics at the entrance of a local supermarket offering opportunistic health screening including blood pressure, random glucose, body mass index and screening spirometry. Findings indicated that 41.2% of participants (n=420) required follow-up for abnormal readings. The opportunistic health screening targeting particular groups of individuals appeared to be effective in identifying significant pathology.

NHS Health Check Programme rapid evidence synthesis: an independent rapid evidence synthesis of the NHS Health Check on attendance, delivery and health outcomes showed that referral rates to lifestyle services are higher among people having an NHS Health Check compared to standard care. The role of lifestyle services in helping people to reduce their risk of CVD were emphasised. The findings from the qualitative and quantitative data (n=68 studies) were also reported:

- A lack of national level studies reporting the characteristics of those who take-up the invitation to an NHS Health Check. Regional studies report uptake between 27% and 53%, similar to national reported uptake (48.3%).
- People do not take up the offer of an NHS Health Check due to lack of awareness or knowledge, competing priorities, misunderstanding the purpose, an aversion to preventive medicine, difficulty getting an appointment with a GP, and concerns about privacy and confidentiality of pharmacies. High levels of satisfaction (over 80%) was reported from those who attended the programme.
- NHS Health Check is associated with small increases in disease detection. There is very little data on behaviour change or referrals to lifestyle services. NHS Health Check is associated with a 3-4% increase in prescribing of statins.

Topic expert feedback

Experts mentioned that there is new evidence on the NHS Health Check programme; as discussed above, this programme is referenced in recommendation 15 of the current guideline.

Topic experts indicated that recommendations in this section are out-of-date because of changes in local and regional structures and responsibilities; they also indicated that the following language and references no longer apply: PCT, Strategic Health Authorities, World class commissioning in the NHS. Current activity is focused around sustainability and transformation partnerships (STPs) through which local NHS organisations and local authorities draw up proposals to improve health and care in the areas they serve.

Experts mentioned overlaps with PHE guidance which cover similar topics; for example, Action on cardiovascular disease: getting serious about prevention (PHE 2016). They also highlighted the links to various national health programmes that can help to reduce cardiovascular disease; for example, Adult obesity: applying All Our Health (PHE 2018), Childhood obesity: a plan for action DH (Sep 2017), Alcohol: applying All Our Health (PHE 2018). It was also noted that there are a range of NICE guidelines which cover behavioural risk factors for CVD (as discussed in appendix A above).

Furthermore, experts acknowledged that there are likely to be various components to local CVD programmes (related to risk factors for CVD) which may be unlinked and difficult to evaluate as a whole.

Topic experts also indicated that budgetary pressures may impact the ability to implement the recommendations at a local level.

One expert noted that the guideline does not focus on specific CVD health inequalities, particularly high risk groups, such as South Asian, Afro-Caribbean groups and low income families.

Impact statement

The new evidence on health checks for CVD prevention identified during the surveillance review indicates that the programme faces a number of barriers, but is contributing to prevention activities and reductions in CVD events. As the NHS health check programme is a major area of activity with some evidence of effect, links to the programme will be maintained. Ongoing and future developments in research and policy will be monitored to assess the relevance of the programme and any impact on the current guideline.

It is recognised that the guideline overlaps with national guidance for CVD prevention. In this context, NICE will continue to monitor policy and guidance developments and ensure that the recommendations are in-line with future changes and remain current.

Although the guideline does not mention specific groups that are at high risk of CVD, as indicated by 1 expert, there is reference to the need to identify groups of the population who are disproportionately affected by CVD and develop strategies with them to address their needs.

At a local level there are various mechanisms through which local commissioners may monitor local CVD prevention programmes. Where programmes are informed by NICE guidance for behavioural risk factors for CVD they should be effective and cost effective. It is acknowledged that budget constraints may affect the scope of CVD prevention programmes and evaluation activities.

New evidence is unlikely to change guideline recommendations.

Recommendation 19: Children and young people

Surveillance decision

This recommendation should not be updated.

Recommendation 19

2018 surveillance summary

No new evidence was identified.

Intelligence gathering

During intelligence gathering we identified overlap with other existing NICE guidelines which have a specific focus on children's and young people's health, for example:

- Obesity (2006) NICE guideline CG43, recommendation 1.1.6.5
- Obesity: working with local communities (2012) NICE guideline PH42, recommendation 9
- Preventing type 2 diabetes: population and community-level interventions (2011) NICE guideline PH35, recommendation 8
- Weight management: lifestyle services for overweight or obese children and young people (2013) NICE guideline PH47
- Physical activity for children and young people (2019) NICE guideline PH17.

Topic expert feedback

In the context of helping children and young people to have a healthy diet and lifestyle, topic experts referred to the Childhood obesity: a plan for action DH (Sep 2017), which covers policies and actions on soft drinks industry levy, food labelling, measures to reduce children's calorie intake and measures to support childhood activity levels.

Impact statement

The present guideline, PH25, cross-refers to NICE guidelines on children and young people's health which are regularly checked for new evidence and policy developments. New policies and evidence on approaches to help children and young people to have a healthy diet and lifestyle would be considered in future surveillance reviews of NICE guidelines which focus on children's and young people's health. Surveillance reviews of these guidelines will closely monitor policy developments in childhood health, such as actions on soft drinks industry levy, food labelling and be updated accordingly.

New evidence is unlikely to change guideline recommendations.

Recommendation 20: Public sector food provision

Surveillance decision

This recommendation should not be updated.

The following editorial corrections are needed:

- Reference to education authorities and government departments and agencies will be removed to remain current and within the remit of NICE guidelines.
- The following text will be added to the recommendation: 'See also recommendation 9 in NICE's guideline on Obesity: working with local communities NICE guideline PH42'.
- The following text will be revised to include sugar: from 'is low in salt and saturated fats', to 'is low in salt, sugar and saturated fats'.
- A cross-reference is made to the 'eatwell plate'. This cross-reference will be updated to The Eatwell Guide (PHE 2017).

Recommendation 20

2018 surveillance summary

No new evidence was identified.

Intelligence gathering

During intelligence gathering we identified overlap with an existing guideline which has a specific focus on public sector food provision, diet and health: Obesity: working with local communities (2012) NICE guideline PH42, recommendation 9.

Intelligence gathering also identified national measures to improve public sector food provision: the School Food Plan was published in July 2013 and covers nutritional quality; the new School Food Standards came in to force from January 2015.

Topic expert feedback

Topic experts indicated that relevant NICE guidelines should take account of Scientific Advisory Nutrition Committee report in 2015 on carbohydrates and health.

One topic expert commented that whilst the recommendation mentions salt and saturated fats in food, current evidence and policies also highlight the risk of sugar and high-calorie in-take; see for example, Sugar reduction and wider reformulation: interim review (PHE 2017) .

It was also mentioned that scientific evidence, public opinion and political willingness to promote a healthier diet in children and adults have all improved since 2010. For example The PHE and Health Select Committee reports on Sugar & Children's Obesity Prevention, and the subsequent Sugary Drinks Industry Levy (2016 Budget, implementation in 2018) and PHE Sugar Reformulation Programme (2017, ongoing).

Impact statement

The important policies and evidence identified by experts would be considered within in future surveillance reviews of NICE guidelines which focus on diet and nutrition. Surveillance reviews of related guidelines will closely monitor policy developments in nutrition and health, such as actions on sugar and food labelling and be updated accordingly.

In order to remain current, the recommendation will be updated to mention sugar, as well as salt and fat. In addition, a cross-reference will be included to Obesity: working with local communities (2012) NICE guideline PH42, recommendation 9, which covers the promotion of healthier food and drink choices.

New evidence is unlikely to change guideline recommendations.

Recommendation 21: Physical activity

Surveillance decision

This recommendation should not be updated.

The following editorial corrections are needed:

- Reference to PCT will be removed.

- There is a cross-reference to 'Physical activity and the environment' [NICE public health guidance 8]. This will be replaced with a cross-reference to the updated Physical activity and the environment NICE guideline [NG90].
- The following text will be added to the recommendation: 'For more information on NICE guidelines for physical activity see NICE's pathway on Physical activity.'

Recommendation 21

2018 surveillance summary

No new evidence was identified.

Intelligence gathering

During intelligence gathering we identified overlap with existing NICE guidelines which focus on physical activity. Everything NICE has said on interventions, programmes and strategies to encourage people of all ages to be physically active is covered in the following NICE pathway:

- Physical activity.

Intelligence gathering also identified Physical activity: applying All Our Health (PHE 2018).

This outlines evidence and guidance to help healthcare professionals and strategic leaders embed physical activity into daily life.

Impact statement

New evidence on physical activity would be considered during future surveillance reviews of NICE guidelines with a specific focus on physical activity. The guideline cross-refers to a number of these guidelines. In addition, and in order to remain current we will add a cross-reference to the NICE physical activity pathway.

New evidence is unlikely to change guideline recommendations.

Recommendation 22: Health impact assessments of regional and local plans and policies

Surveillance decision

This recommendation should not be updated.

The following editorial correction is needed:

- Reference to PCT will be removed.

Recommendation 23: Take-aways and other food outlets

Surveillance decision

This recommendation should not be updated.

The following editorial corrections are needed:

- Reference to education authorities and government departments and agencies will be removed to remain current and within the remit of NICE guidelines.
- The following text will be added to the recommendation: ‘see NICE's guideline on Obesity: working with local communities NICE guideline PH42’.
- A cross-reference is made to the 'eatwell plate'. This cross-reference will be updated to The Eatwell Guide (PHE 2017).

Recommendation 23

2018 surveillance summary

No new evidence was identified.

Intelligence gathering

During intelligence gathering we identified a PHE publication which focuses on take-away and other food outlets: Strategies for encouraging healthier 'out of home' food provision: toolkit (PHE 2017). This toolkit helps local authorities and businesses to provide and promote healthier options for food eaten away from home.

Topic expert feedback

One topic expert highlighted a recent PHE briefing which relates to regulation and opportunities to limit the number of fast food takeaways (especially near schools) and ways to make fast food offers healthier: Obesity and the environment briefing: regulating the growth of fast food outlets (PHE 2014). Reference was also made to the Local Government Association’s, Tipping the scales: Case studies on the use of planning powers to limit hot food takeaway (LGA 2016), which provides case studies about the use of planning powers as part of a community healthy weight strategy .

Impact statement

The briefing and toolkit identified are relevant to this recommendation provide recent information about the regulatory framework and details about planning and regulation that complements the NICE recommendation. The recommendation is current and up to date.

New evidence is unlikely to change guideline recommendations.

Recommendation 24: Nutrition training

Surveillance decision

This recommendation should not be updated.

The following editorial correction is needed:

- A cross-reference is made to the 'eatwell plate'. This cross-reference will be updated to The Eatwell Guide (PHE 2017).

Areas not currently covered in the guideline

Information from intelligence gathering

Experts acknowledged that that there is a wealth of evidence and guidance on the identification of people at increased risk of cardiovascular disease and in practice people are being identified but linkage to care is an issue. Experts noted that the evidence base on linkage to care is still developing and that it may be too premature for NICE to develop guideline recommendations in this area.

New section considered in surveillance

We conducted focused searches on the following areas where topic experts suggested there may be new evidence related to primary prevention of CVD:

1) workplace interventions,

2) social media approaches.

2018 surveillance approach

For 2018 surveillance, 2 searches were conducted: Evidence was searched from 1 January 2010 – 21 November 2017 across 3 databases: Medline, Medline-in-process and Medline e-publications. Based on the PH25 scope, we looked for studies of interventions that addressed **two or more** CVD risk factors. The standard surveillance review process of using RCT and systematic review selection criteria was used for this search.

- This research yielded 6 studies that were eligible for inclusion for workplace approaches. This new evidence has been considered for possible addition as a new section of the guideline.
- This research yielded no studies that were eligible for inclusion for social media approaches.

Surveillance decision – primary prevention of CVD through workplace interventions

This section should not be added.

CVD prevention: workplace interventions

2018 surveillance summary

The current surveillance review identified 6 RCTs that reported on workplace interventions for primary prevention of cardiovascular disease. One of the inclusion criteria was that interventions addressed two or more CVD risk factors.

An RCT(8) among 566 nurses working in 20 nursing homes for elderly people in 6 cities examined a workplace intervention (mobile app-based tool to help users make healthy lifestyle changes such as losing weight, exercise more, and quit smoking). It found that the intervention had a modest yet beneficial effect on body weight and body fat percentage in the health care sector staff.

One RCT(9) evaluated the long-term effects of a risk-adjusted multimodal 15-week intervention in high-risk participants (n=447) without a history of CVD. It concluded that a significant reduction in the composite cardiovascular events was observed in the intervention group compared with the control group.

An RCT(10) examined whether a behavioural lifestyle intervention program delivered at a

worksite setting. It was found to be effective in improving type-2 diabetes and cardiovascular disease risk factors. The year-long program focused on weight loss and increasing physical activity. A worksite behavioural lifestyle intervention had significantly improved the risk factors for type-2 diabetes and cardiovascular disease.

A subgroup analysis of an RCT(11) that aimed to evaluate the personal health technologies in supporting employee health promotion. The associations between sustained usage and changes in health-related outcomes (weight, aerobic fitness, blood pressure and cholesterol) were examined. Of the participants (n=114), 29.9% were classified as sustained users of Web or mobile technologies. The sustained users achieved better weight-related outcomes than non-sustained users, however no significant differences observed in body fat percentage and waist circumference.

An RCT(12) that examined the effectiveness of an individually tailored intervention for improvement lifestyle behaviour, health indicators, prevention and reduction of overweight among construction workers. The intervention group (n=162) received individual coaching sessions, tailored information, and materials to improve lifestyle behaviour during a 6-month period; the control group (n=152) received usual care. Intervention participants showed positive changes in vigorous physical activities and intake of sugar-sweetened beverages compared to controls, as well as effects on weight-related outcomes at 6 months.

A cluster RCT(13) including 16 occupational physicians and 523 employees evaluated the effectiveness of a draft occupational health guideline, compared to usual care. Guideline-based care consisted of providing advice for employers on how to assess and intervene on the obesogenic work environment, conducting five face-to-face behavioural change counselling sessions. No significant differences were found between the intervention and control group on waist circumference, body mass index, diastolic blood pressure, or quality of life indicators after 18-months follow-up.

Impact statement

New evidence from 6 RCTs on workplace intervention aiming to improve CVD risk factors showed modest benefits to cardiovascular outcome events and other health markers. The sustained users in one study achieved better weight-related outcomes than non-sustained users. No significant benefit was observed in complying with occupational health guideline for employees in one study.

Workplace interventions for primary prevention of cardiovascular disease represent a potentially promising area in helping to reduce cardiovascular disease based on short-term outcome results. However, the evidence is thinly spread across a range of different intervention types.

There exists some doubt around the extent that CVD prevention workplace intervention would become widely implemented or help to reduce health inequalities, given the scarce resources available to some employers, particularly in sectors of industry employing routine and manual workers and small sized employers.

Overall, it is considered that more evidence is needed before considering any changes in current recommendations regarding workplace interventions for CVD prevention.

New evidence is unlikely to change guideline recommendations.

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