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Ten questions to ask if you are scrutinising… cardiovascular disease prevention through planning and procurement activities, and regional programmes

NHS
National Institute for Health and Clinical Excellence

Contents

The Centre for Public Scrutiny (CfPS)

The Centre for Public Scrutiny is an independent charity that promotes the value of scrutiny in modern and effective government, not only to hold executives to account but also to create a constructive dialogue between the public and its elected representatives to improve the quality of public services.

The Centre has received funding from the Department of Health to run a support programme for overview and scrutiny committees as they develop their power to promote the wellbeing of local communities through effective scrutiny of healthcare planning and delivery and wider public health and social care issues.

National Institute for Health and Clinical Excellence (NICE)

The National Institute for Health and Clinical Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.

NICE makes recommendations to the NHS on:

- new and existing medicines, treatments and procedures
- treating and caring for people with specific diseases and conditions.

NICE makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness and disease.

Acknowledgements

CfPS and NICE are grateful to those who helped develop this guide. A list of acknowledgements is available on page 16.

Introduction

This guide is one of a series designed to help health overview and scrutiny committees (OSCs) carry out their work on various health, healthcare and social care issues. Other guides in the series include:

- ‘Child and adolescent mental health’ (CfPS 2006)
- ‘NHS service design or reconfiguration’ (CfPS 2007a)
- ‘The effectiveness of your local hospital’ (CfPS 2007c)
- ‘Mainstream health services for people with learning disabilities’ (CfPS 2008)
- ‘Promoting physical activity through planning, transport, and the physical environment’ (CfPS 2009)
- ‘End of life care for adults’ (CfPS 2009b)
- ‘Eye care’ (CfPS 2009c)
- ‘Local involvement networks’ (CfPS 2009d)

This guide can help OSCs influence development of the 10-year local delivery framework (LDF) for their area to ensure it supports programmes, planning and procurement efforts which aim to reduce the prevalence of cardiovascular disease (CVD) among the local population.

It is based on recommendations made by the National Institute for Health and Clinical Excellence (NICE) in public health guidance 25 on ‘Prevention of cardiovascular disease’ (2010).

These are national, evidence-based recommendations on how to effectively plan, develop, resource and lead population-level programmes to prevent cardiovascular disease. They demonstrate the importance of regional programmes and initiatives in this area and the need to evaluate how such work impacts on the public’s health.

NICE has also produced other guidance which complements and supports this work (see related NICE guidance section).

Reviewing the local delivery framework and its impact on the prevention of cardiovascular disease

NICE guidance should be taken into account during the development of local and regional strategies, for example, regeneration and transport plans. OSCs have a key role in establishing to what extent this is happening.

These ten questions may help committee members when they are preparing for a review, or in developing their lines of questioning for invited witnesses at a formal, public meeting.

Consulting others

To get the full picture, OSCs need to speak to people representing a variety of perspectives. Possible witnesses are:

- directors of public health
- local commissioning leads
- local cardiac network leads
- local authority planning officers
- food procurement leads (for local authorities, health services, care homes, prisons and schools)
- trading standards and licensing enforcement leads
- environmental health officers
- directors of adult and children's social services
- head teachers, school governors and principals of academies
- local strategic partnership leads
- representatives from patient groups, the community and voluntary sector
- transport planners
- executive members with a remit for health

- directors of leisure services
- representatives of children and young people's partnerships
- non-government organisations and charities involved in improving the public's health.

Ten questions to ask if you are scrutinising cardiovascular disease prevention through planning and procurement activities, and regional programmes

Questions for OSC Members

1. Why should overview and scrutiny committees review the impact of local authority and primary care strategies on cardiovascular disease?

In England in 2007, cardiovascular disease (CVD) led to nearly 160,000 deaths – that is, nearly 34% of all deaths. Premature death from the condition (before the age of 75) is up to six times higher among lower socioeconomic groups. It is approximately 50% higher than average among South Asian groups[1]. Most premature deaths from CVD are preventable.

CVD is generally caused by reduced blood flow to the heart, brain or body caused by atheroma – a blockage or swelling in the artery walls, or thrombosis, which is a blood clot inside a blood vessel.

Diet, lack of physical activity, smoking and tobacco use and excessive alcohol consumption are all risk factors for CVD. An individual's lifetime risk of CVD is strongly influenced by these factors from childhood so it is important to ensure

[1] Used here, the term 'South Asian' refers to people originating from India, Pakistan and Bangladesh.

everyone, including children, has a healthy balanced diet, are physically active and do not smoke.

Tackling the risk factors for CVD at the population level within your region will bring savings for the local health economy and ensure a range of health outcomes are achieved, including those on adult and child obesity, all-age mortality rate, life expectancy and on reducing health inequalities. In addition, it will help reduce the number of cases of a range of other chronic conditions such as diabetes.

A scrutiny review of CVD can involve talking to a range of people working for councils and other parts of the public sector. In two tier areas, county councils and district councils need to co-ordinate their approach to reviewing CVD. OSCs may already have some experience of working together to scrutinise health issues in their regions. A review of the regional approach to reducing and preventing CVD would fit well with existing arrangements. Alternatively, such a review might be a way of bringing together OSCs to carry out some joint scrutiny work.

2. What information do OSCs need to prepare for the review?

OSC members should be aware of the risk factors for CVD, including the social and wider determinants of health[2]. They should also be aware of the key evidence-based population approaches that have been proven effective. As an example, local policies should make it possible for people to have a healthy diet by making various foods physically accessible and affordable. This should include fruit, vegetables, whole grains, fish and polyunsaturates,

[2] Dahlgren G and Whitehead M (1991): Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

while minimising the intake of salt, sugar, saturated fats and fast food.
A list of further information and background reading is provided on page 15.

In addition, a comprehensive local tobacco control strategy is essential to protect children from the dangers of second-hand smoke, to prevent young people from starting to smoke and to help those who already smoke to quit.[3]

Questions to ask…..

3. What services are available as part of the CVD prevention programme – and do they have a population-based approach?

Helping people to change their behaviour is an important part of work to prevent CVD. However, interventions focused on individuals will not reduce the overall prevalence within a given population, nor will they prevent new cases from occurring. Population-based interventions on the other hand, aim to tackle the social, economic and environmental factors that underpin CVD risks. As such, they are more likely to reduce health inequalities, as they do not rely on an individual's knowledge or ability to choose healthier options. Rather, they aim to improve social environments and ensure the healthy choice is the easy choice. This may involve planning, regulation, legislation or rearranging the physical layout of communities.

To illustrate this impact, data pooled from European CVD prevention strategies estimate that a population-wide reduction of 10% in blood cholesterol, blood pressure and smoking prevalence would save 9120 lives (per million population) over 10 years.

In contrast, treating 40% of high-risk individuals with a 'polypill' (to treat individuals with high cholesterol and high blood pressure) would save 3720

[3] For more details see NICE Public Health guidance PH14 "Preventing the uptake of smoking by children and young people"
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lives (per million). This figure also assumes long-term adherence to the medication, which is not always achieved.

Examples of successful population-based programmes can be found in 'Communities for health: learning from the pilots' (Department of Health and Inequalities Unit 2007).
OSCs could ask:

- Are there publicly-funded, population-wide programmes to prevent CVD within our region?
- If so, do they follow the good practice criteria detailed in NICE's guidance?
- Are they linked to existing interventions for people at particularly high risk of CVD, such as the NHS Health Checks programme?
- Do local regeneration policies include health as a priority area?

4. Are CVD prevention programmes sustainable for at least 5 years?

For a population-level CVD prevention programme to be effective, NICE recommends that it should last for a minimum of 5 years. OSCs could ask:

- Is there a long-term plan in place for this within the region?
- What local political commitment exists to fund such programmes over a 5-year period?
- How is multi-agency working enabled as part of this work?
- Are current programmes adequately staffed with dedicated leads? (NICE recommends staff should not have CVD prevention programme tasks added to their workload without being relieved of other tasks).

- Have senior figures been identified within NHS primary care organisations and local authorities as champions for CVD prevention?

5. Do planners and regeneration leads consider the impact of their policies on CVD locally?

There is clear evidence that the built environment can have a positive impact on levels of CVD within a population.[4] For example, that the design of outdoor space can encourage physically active modes of travel such as cycling.

OSCs could ask:

- Has part of the local transport plan been allocated to promote walking, cycling and other forms of travel that involve physical activity?
- Has there been an improvement in the way local strategies are used to increase physical activity levels?
- How does your region compare to others in significant areas such as spatial and transport planning, or the siting and regulation of food retailing?
- Has a benchmarking system been considered to help measure current and future progress on encouraging and supporting initiatives in these areas?
- Are physical activity initiatives referenced within local planning and procurement policies?

- [4] See 'Promoting physical activity through planning, transport, and the physical environment' (CfPS 2009)

6. How are local policies, strategies and plans developed?

NICE's guidance outlines a number of principles that need to be applied when developing policies, strategies and plans in relation to transport, public open spaces, public sector food provision and regulation of the local food economy.

OSCs could ask:

- Is there evidence of CVD prevention being a priority for local health and local authority leads when planning for changes to regional travel, the physical environment, workforce food provision or the local food economy?
- If this is the case what outcomes have been delivered as a result?
- Do all new policies and planning applications undergo a Health Impact Assessment[5]?
- If so, what evidence is there of changes being made because of these assessments? What health improvements can be tracked in the local population as a result?
- Are developers encouraged to ensure local facilities and services are easily accessible on foot, by bicycle or by other modes of transport involving physical activity?

[5] Health Impact Assessment is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.
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7. Is the impact of planning on the local population's health considered and how do planners and local councillors assess the potential affect of their decisions?

Policies in a wide variety of areas can have a positive or negative impact on CVD risk factors – and frequently the consequences are unintended. For example, planning regulations and policies can affect a community's access to outdoor space in the built environment. OSCs could ask:

- Does local authority Health Impact Assessments include a reference to the prevention of CVD? If yes, what outcomes were targeted and have been achieved?
- Do those responsible for carrying out Health Impact Assessments have access to high quality data?
- Do they also have adequate knowledge of the key factors to consider when assessing how policies impact on CVD rates?
- Is there evidence of planning officers being trained to conduct Health Impact Assessments as part of their routine work?
- Have existing powers been used to set limits for the number of take-aways and other food outlets in specific areas, including directives to specify the distance from schools?

8. Do local authority and NHS procurement managers include health in their specifications for providers?

NICE's guidance highlights how local authorities and primary care providers and commissioners can adopt practices to help prevent CVD. Local authority and NHS procurement managers could play a key role here.

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OSCs could ask:

- Has the local authority and those responsible for local health commissioning ensured healthy balanced meals and healthier food options are provided for the public, patients and staff?
  (For example, via service specifications for in-house catering or vending machines.)

- Do procurement leads include standards for the nutritional content of foods within tender documents and service level agreements?
  (For example, detail on maximum levels of fat, salt and sugar within the foods provided.)

- Where such standards are used, are they reviewed as part of the contract management process?

- Are these healthy food principles also included in specifications for suppliers of food to care homes and adult social services (for example, within contracts for meals-on-wheels provision)?

- Are attempts made to ensure healthier food and drink options are available at community events such as festivals?

- Are Health Impact Assessments included in supplier specifications across all procurement streams?

9. Do local authority services for children and young people treat health as a high priority?

Local authorities can help children and young people to develop positive, life-long habits in relation to food and physical activity. This can be achieved by ensuring the messages conveyed about food, the food and drink available –

and where it is consumed – is conducive to a healthy diet and that adequate and safe spaces to encourage physical activity are available.

OSCs could ask:

- Has the need for children and young people to be physically active been addressed within local plans, for example, including walking within school travel schemes?

- Have adequate play spaces and opportunities for formal and informal physical activity been provided for children and young people?

- Is there evidence of steps being taken to ensure the availability of healthier options such as fruit and water in schools, local authority settings and in venues used for school trips?

- Are venues frequented by children and young people (and supported by public money) encouraged to resist sponsorship or product placement from companies associated with foods high in fat, sugar or salt (this includes fun parks and museums)?

10. Do local authorities ensure that providing access to an affordable, healthy diet is given a high priority?

Public sector organisations provide around one in three meals eaten outside the home. Improving the nutritional quality of the food and drink provided would help ensure many people have access to an affordable, healthy diet and lower the risk of CVD (a healthy diet is defined as being low in salt, saturated fats and sugar). OSCs could ask:

- Have all publicly-funded catering departments met national dietary guidelines? This includes catering departments in schools, hospitals and public sector work canteens.

- Have local authorities and primary care organisations taken steps to ensure all food procured by, and provided for, people working in the public sector – and all food provided for people who use public services:
  - is low in salt and saturated fats
  - is nutritionally balanced and varied, in line with recommendations made in the 'eatwell plate'[6]
  - does not contain industrially produced trans fatty acids (IPTFAs)?

- Is information on the links between nutrition and health included as an integral part of training for catering managers?

Further information

- Refer to local documents, such as the 'Annual public health report' and sections of the local development framework.

- 'Active travel strategy' (Department for Transport 2010)

- 'A smokefree future: a comprehensive tobacco control strategy for England' (DH 2010)
- 'Be active be healthy. A plan for getting the nation moving' (DH 2009)
- 'Fair society, healthy lives: strategic review of health inequalities in England post 2010' (Marmot 2010) [online]. Available from www.ucl.ac.uk/gheg/marmotreview/Documents/finalreport
- 'Food 2030' (Department for Environment, Food and Rural Affairs 2010)
- 'Healthy weight, healthy lives: a cross-government strategy for England' (DH 2008a)
- 'Tackling health inequalities: 2007 status report on the programme for action' (DH 2008b)

[6] The 'eatwell plate' illustrates food types and the proportions needed for a well-balanced diet. Further information via www.eatwell.gov.uk/healthydiet/eatwellplate/

- ‘Tackling inequalities in life expectancy in areas with the worst health and deprivation’ (National Audit Office 2010)

Related NICE guidance

- Promoting physical activity for children and young people. NICE public health guidance 17 (2009). Available from www.nice.org.uk/guidance/PH17

- Identifying and supporting people most at risk of dying prematurely. NICE public health guidance 15 (2008). Available from www.nice.org.uk/guidance/PH15

- Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008). Available from www.nice.org.uk/guidance/PH14

- Promoting physical activity in the workplace. NICE public health guidance 13 (2008). Available from www.nice.org.uk/guidance/PH13

- Maternal and child nutrition. NICE public health guidance 11 (2008). Available from www.nice.org.uk/guidance/PH11

- Smoking cessation services. NICE public health guidance 10 (2008). Available from www.nice.org.uk/guidance/PH10

- Physical activity and the environment. NICE public health guidance 8 (2008). Available from www.nice.org.uk/guidance/PH8

- Behaviour change. NICE public health guidance 6 (2007). Available from www.nice.org.uk/guidance/PH6

- Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007). Available from www.nice.org.uk/guidance/PH5

- Four commonly used methods to increase physical activity. NICE public health guidance 2 (2006). Available from www.nice.org.uk/guidance/PH2
- Brief interventions and referrals for smoking cessation. NICE public health guidance 1 (2006). Available from www.nice.org.uk/guidance/PH1
- Obesity. NICE clinical guideline 43 (2006). Available from www.nice.org.uk/guidance/CG43

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