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NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Prevention of cardiovascular disease

This quick reference guide presents the recommendations made in 'Prevention of cardiovascular disease at population level'. Cardiovascular disease (CVD) includes coronary heart disease (CHD), stroke and peripheral arterial disease. These conditions are frequently brought about by the development of atheroma and thrombosis (blockages in the arteries). They are also linked to conditions such as heart failure, chronic kidney disease and dementia.

The guidance is for government, the NHS, local authorities, industry, and all those whose actions influence the population's cardiovascular health. This includes commissioners, managers and practitioners working in local authorities and the wider public, private, voluntary and community sectors. It may also be of interest to members of the public.

The guidance complements, but does not replace, NICE guidance on: smoking cessation and prevention and tobacco control, physical activity, obesity, hypertension and maternal and child nutrition. It will also complement NICE guidance on alcohol misuse. (See related NICE guidance, page 26 for a list of publications.)

NICE public health guidance 25

This guidance was developed using the NICE public health programme process.

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health. This guidance represents the views of NICE and was arrived at after careful consideration of the evidence available. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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A national framework for action

Changes in cardiovascular disease (CVD) risk factors can be brought about by intervening at the population and individual level. Government has addressed – and continues to address – the risk factors at both levels.

Interventions focused on changing an individual's behaviour are important and are supported by a range of existing NICE guidance (see page 26, 'Related NICE guidance').

Changes at the population level could lead to further substantial benefits and this guidance breaks new ground for NICE, by focusing on action to bring about such changes. They may be achieved in a number of ways but national or regional policy and legislation are particularly powerful levers[1].

This guidance makes the case that CVD is a major public health problem.

Recommendations 1 to 12 are based on extensive and consistent evidence. This suggests that the policy goals identified provide the outline for a sound, evidence-based national framework for action which is likely to be the most effective and cost-effective way of reducing CVD at population level.

It would require a range of legislative, regulatory and voluntary changes including the further development of existing policies.

The framework would be established through policy, led by the Department of Health. It would involve government, government agencies, industry and key, non-governmental organisations working together.

The final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes.

The recommendations for practice (recommendations 13 to 24) support and complement – and are supported by – these policy options.

[1] Blas E, Gilson L, Kelly MP et al. (2008) Addressing social determinants of health inequities: what can the state and civil society do? The Lancet 372: 1684–9.
Kelly MP, Stewart E, Morgan A et al. (2009a) A conceptual framework for public health: NICE's emerging approach. Public Health 123: e14–20.
Marmot M (2010) Fair society, healthy lives: strategic review of health inequalities in England post 2010 [online]. Available from www.ucl.ac.uk/gheg/marmotreview/Documents/finalreport
Rose G (2008) Rose's strategy of preventive medicine. Commentary by Khaw KT, Marmot M. Oxford: Oxford University Press.

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Recommendations for policy

Who should take action?

As well as the Department of Health, the following should be involved:

- Chief Medical Officer
- National Clinical Director for Coronary Heart Disease
- Government Chief Scientific Adviser
- Department of Health Chief Scientist
- Advertising Standards Authority
- Department for Business, Innovation and Skills
- Department for Culture, Media and Sport
- Department for Education
- Department for Environment, Food and Rural Affairs
- Department for Transport
- Department of Communities and Local Government
- Food Standards Agency
- HM Treasury
- National Institute for Health Research
- Ofcom
- Other research organisations (for example, the Medical Research Council and the Economic and Social Research Council).

Other key players include:

- caterers
- food and drink producers
- food and drink retailers
- marketing and media industries
- national, non-governmental organisations including, for example, the British Heart Foundation, Cancer Research UK, Diabetes UK, National Heart Forum, the Stroke Association and other chronic disease charities
- the farming sector.

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Salt

High levels of salt in the diet are linked with high blood pressure which, in turn, can lead to stroke and coronary heart disease. High levels of salt in processed food have a major impact on the total amount consumed by the population.

Over recent years the food industry, working with the Food Standards Agency, has made considerable progress in reducing salt in everyday foods. As a result, products with no added salt are now increasingly available. However, it is taking too long to reduce average salt intake among the population. Furthermore, average intake among children is above the recommended level[2] – and some children consume as much salt as adults. Progress towards a low-salt diet needs to be accelerated as a matter of urgency.

Policy goal

Reduce population-level consumption of salt. To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 1

What action should be taken?

- Accelerate the reduction in salt intake among the population. Aim for a maximum intake of 6 g per day per adult by 2015 and 3 g by 2025.
- Ensure children's salt intake does not exceed age-appropriate guidelines (these guidelines should be based on up-to-date assessments of the available scientific evidence).
- Promote the benefits of a reduction in the population's salt intake to the European Union (EU). Introduce national legislation if necessary.
- Ensure national policy on salt in England is not weakened by less effective action in other parts of the EU.
- Ensure food producers and caterers continue to reduce the salt content of commonly consumed foods (including bread, meat products, cheese, soups and breakfast cereals). This can be achieved by progressively changing recipes, products and manufacturing and production methods.
- Establish the principle that children under 11 should consume substantially less salt than adults. (This is based on advice from the Scientific Advisory Committee on Nutrition.)
- Support the Food Standards Agency so that it can continue to promote – and take the lead on – the development of EU-wide salt targets for processed foods.
- Establish an independent system for monitoring national salt levels in commonly consumed foods.
- Ensure low-salt products are sold more cheaply than their higher salt equivalents.
- Clearly label products which are naturally high in salt and cannot meaningfully be reformulated. Use the Food Standards Agency-approved traffic light system. The labels should also state that these products should only be consumed occasionally.
- Discourage the use of potassium and other substitutes to replace salt. The aim of avoiding potassium substitution is twofold: to help consumers' readjust their perception of 'saltiness' and to avoid additives which may have other effects on health.
- Promote best practice in relation to the reduction of salt consumption, as exemplified in these recommendations, to the wider EU.

[2] www.sacn.gov.uk/reports_position_statements/reports/salt_and_health_report.html

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Saturated fats

Reducing general consumption of saturated fat is crucial to preventing CVD. Over recent years, much has been done (by the Food Standards Agency, consumers and industry) to reduce the population's intake. Consumption levels are gradually moving towards the goal set by the Food Standards Agency: to reduce population intake of saturated fat from 13.3% to below 11% of food energy.

However, a further substantial reduction would greatly reduce CVD and deaths from CVD. Taking the example of Japan (where consumption of saturated fat is much lower than in the UK), halving the average intake (from 14% to 6–7% of total energy) might prevent approximately 30,000 CVD deaths annually. It would also prevent a corresponding number of new cases of CVD annually. (Note that low-fat products are not recommended for children under 2 years, but are fine thereafter.)

Policy goal

Reduce population-level consumption of saturated fat. To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 2

What action should be taken?

- Encourage manufacturers, caterers and producers to reduce substantially the amount of saturated fat in all food products. If necessary, consider supportive legislation. Ensure no manufacturer, caterer or producer is at an unfair advantage as a result.
- Create the conditions whereby products containing lower levels of saturated fat are sold more cheaply than high saturated fat products. Consider legislation and fiscal levers if necessary.
- Create favourable conditions for industry and agriculture to produce dairy products for human consumption that are low in saturated fat.
- Continue to promote semi-skimmed milk for children aged over 2 years. This is in line with the American Heart Association's pediatric dietary strategy[3].

[3] American Heart Association (2005) Dietary recommendations for children and adolescents. A guide for practitioners: consensus statement from the American Heart Association. Circulation 112: 2061–75.

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Trans fats

Industrially-produced trans fatty acids (IPTFAs) constitute a significant health hazard. In recent years many manufacturers and caterers, with the encouragement of the Food Standards Agency and other organisations, have considerably reduced the amount of IPTFAs in their products.

However, certain sections of the population may be consuming a substantially higher amount of IPTFAs than average (for instance, those who regularly eat fried fast-food). It is important to protect all social groups from the adverse effects of IPTFAs.

In some countries and regions (for instance, Denmark, Austria and New York), IPTFAs have been successfully banned. A study for the European Parliament recently recommended that it, too, should consider an EU-wide ban. In the meantime, some large UK caterers, retailers and producers have removed IPTFAs from their products.

Policy goal

Ensure all groups in the population are protected from the harmful effects of IPTFAs. To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 3

What action should be taken?

- Eliminate the use of IPTFAs for human consumption.
- In line with other EU countries (specifically, Denmark and Austria), introduce legislation to ensure that IPTFA levels do not exceed 2% in the fats and oils used in food manufacturing and cooking.
- Direct the bodies responsible for national surveys to measure and report on consumption of IPTFAs by different population subgroups – rather than only by mean consumption across the population as a whole.
- Establish guidelines for local authorities to monitor independently IPTFA levels in the restaurant, fast-food and home food trades using existing statutory powers (in relation to trading standards or environmental health).
- Create and sustain local and national conditions which support a reduction in the amount of IPTFAs in foods, while ensuring levels of saturated fat are not increased. Encourage the use of vegetable oils high in polyunsaturated and monounsaturated fatty acids to replace oils containing IPTFAs. Saturated fats should not be used as an IPTFA substitute.
- Develop UK-validated guidelines and information for the food service sector and local government on removing IPTFAs from the food preparation process. This will support UK-wide implementation of any legislation produced on IPTFAs.

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Marketing and promotions aimed at children and young people

Eating and drinking patterns get established at an early age so measures to protect children from the dangers of a poor diet should be given serious consideration.

Current advertising restrictions have reduced the number of advertisments for foods high in fat, salt or sugar during television programmes made for children and young people.

However, advertisements, promotions, product placements and sponsorship shown between programmes for older audiences also have a powerful influence on children and young people.

Marketing bans have been successfully introduced in several other countries; evidence shows that a 9pm watershed for such TV advertisements would reduce children and young people's exposure to this type of advertising by 82%[4].

Policy goal

Ensure children and young people under 16 are protected from all forms of marketing, advertising and promotions (including product placements) which encourage an unhealthy diet. To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 4

What action should be taken?

- Develop a comprehensive, agreed set of principles for food and beverage marketing aimed at children and young people. This could be similar to the 'Sydney principles'[5]. They should be based on a child's right to a healthy diet.
- Extend TV advertising scheduling restrictions on food and drink high in fat, salt or sugar (as determined by the Food Standards Agency's nutrient profile) up to 9pm.
- Develop equivalent standards, supported by legislation, to restrict the marketing, advertising and promotion of food and drink high in fat, salt or sugar via all non-broadcast media. This includes manufacturers' websites, use of the Internet generally, mobile phones and other new technologies.
- Ensure restrictions for non-broadcast media on advertising, marketing and promotion of food and drink high in fat, salt or sugar are underpinned by the Food Standards Agency nutrient profiling system.

[4] Office of Communications (2006) Annex 7 – impact assessment. Annex to consultation on television advertising of food and drink to children [online]. Available from www.ofcom.org.uk/consult/condocs/foodads_new/ia.pdf

[5] Swinburn B, Sacks G, Lobstein T et al. (2007) The 'Sydney principles' for reducing the commercial promotion of foods and beverages to children. Public Health Nutrition 11 (9): 881–6.

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Commercial interests

If deaths and illnesses associated with CVD are to be reduced, it is important that food and drink manufacturers, retailers, caterers, producers and growers, along with associated organisations, deliver goods that underpin this goal. Many commercial organisations are already taking positive action.

Policy goal

Ensure dealings between government, government agencies and the commercial sector are conducted in a transparent manner that supports public health objectives and is in line with best practice. (This includes full disclosure of interests.) To achieve this, the following are among the measures that should be considered.

Recommendation 5

What action should be taken?

- Encourage best practice for all meetings, including lobbying, between the food and drink industry and government (and government agencies). This includes full disclosure of interests by all parties. It also involves a requirement that information provided by the food and drink, catering and agriculture industries is available for the general public and is auditable.

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Product labelling

Clear labelling which describes the content of food and drink products is important because it helps consumers to make informed choices. It may also be an important means of encouraging manufacturers and retailers to reformulate processed foods high in saturated fats, salt and added sugars.

Evidence shows that simple traffic light labelling consistently works better than more complex schemes[6].

Policy goals

- Ensure the Food Standards Agency's integrated front-of-pack labelling system is rapidly implemented.
- Ensure labelling regulations in England are not adversely influenced by EU regulation.

To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 6

What action should be taken?

- Establish the Food Standards Agency's single, integrated, front-of-pack traffic light colour-coded system as the national standard for food and drink products sold in England. This includes the simple, traffic light, colour-coding visual icon and text which indicates whether food or drink contains a 'high', 'medium' or 'low' level of salt, fat or sugar. It also includes text to indicate the product's percentage contribution to the guideline daily amount (GDA) from each category.
- Consider using legislation to ensure universal implementation of the Food Standards Agency's front-of-pack traffic light labelling system.
- Develop and implement nutritional labelling for use on shelves or packaging for bread, cakes, meat and dairy products displayed in a loose or unwrapped state or packed on the premises. The labelling should be consistent with the Food Standards Agency's traffic light labelling system.
- Ensure food and drink labelling is consistent in format and content. In particular, it should refer to salt (as opposed to sodium), the content per 100 g and use kcals as the measure of energy.
- Continue to support the Food Standards Agency in providing clear information about healthy eating.
- Ensure the UK continues to set the standard of best practice by pursuing exemption from potentially less effective EU food labelling regulations when appropriate.

[6] Kelly B, Hughes C, Chapman K et al. (2009b) Consumer testing of the acceptability and effectiveness of front-of-pack food labelling systems for the Australian grocery market. Health Promotion International 24 (2): 120–9.

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Health impact assessment

Policies in a wide variety of areas can have a positive or negative impact on CVD risk factors – and frequently the consequences are unintended. The Cabinet Office has indicated that, where relevant, government departments should assess the impact of policies on the health of the population[7]. Well-developed tools and techniques exist for achieving this.

Policy goals

- Ensure government policy is assessed for its impact on CVD.
- Ensure any such assessments are adequately incorporated into the policy making process.

To achieve this, the following are among the measures that should be considered.

Recommendation 7 (see also recommendation 22)

What action should be taken?

- Assess (in line with the Cabinet Office requirement) all public policy and programmes for the potential impact (positive and negative) on CVD and other related chronic diseases. In addition, assess the potential impact on health inequalities. Assessments should be carried out using health and policy impact assessment and other similar, existing tools.
- Monitor the outcomes of policy and programmes after the assessment and use them to follow up and amend future plans.
- Make health impact assessment mandatory in specific scenarios. (Note that strategic environmental assessment, environmental impact assessment and regulatory impact assessment are already mandatory in certain contexts.)

[7] www.cabinetoffice.gov.uk/secretariats/cabinet_committee_business/annexes/checklist.aspx

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Common agricultural policy

The common agricultural policy (CAP) is the overarching framework used by EU member countries to form their own agricultural policies. The burden of diet-related disease has grown considerably since CAP was first implemented.
CAP reform offers a significant opportunity to address the burden of CVD. However, there are still a number of significant 'distortions' in relation to certain food prices and production processes which potentially increase the burden of disease. Further reform should aim to remove these distortions to promote health and wellbeing and to provide a basis for UK government action to prevent CVD[8].
The CAP has two main 'pillars': market measures (first pillar) and rural development policy (second pillar). Recent CAP reform has shifted money from the first to the second pillar which now focuses more on 'public goods'. However, health has not been formally recognised as a 'public good'.
CAP reforms have begun to address this issue, but a clearer focus on CVD and its antecedents (that is, the production of foods high in fat, sugar or salt) is needed.

Policy goals

- Ensure promoting health and reducing disease is made an explicit part of the CAP's 'public goods' so that European money promotes the wellbeing of EU citizens[9].
- Ensure CAP spending takes adequate account of its potential impact on CVD risk factors and is used in a way that optimises the public health outcomes.

To achieve this, the following are among the measures that should be considered.

Recommendation 8

What action should be taken?

- Negotiate at EU and national level to ensure the CAP takes account of public health issues. Health benefits should be an explicit, legitimate outcome of CAP spending. This can be achieved through formal recognition of health as a 'public good'.
- Progressively phase out payments under 'pillar one' so that all payments fall under 'pillar two'. This will allow for better protection of health, climate and the environment. It will also improve and stimulate economic growth.
- Encourage the principle that future 'pillar two' funds should reward or encourage the production of highly nutritious foods such as fruit, vegetables, whole grains and leaner meats.
- Negotiate to ensure the European Commission's impact assessment procedure takes cardiovascular health and other health issues into account. (Impact assessment is part of the European Commission's strategic planning and programming cycle.)

[8] Lloyd Williams F, Mwatsama M, Birt C et al. (2008) Estimating the cardiovascular mortality burden attributable to the European Common Agricultural Policy on dietary saturated fats. Geneva: World Health Organization.
Lock K, Pomerleau J (2005) Fruit and vegetable policy in the European Union: its effect on cardiovascular disease. Brussels: European Health Network.

[9] The scope of what are regarded as 'European public goods' in the EU is broader than the strict definition of a 'public good' used by some economists.

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Physically active travel

Travel offers an important opportunity to help people become more physically active. However, inactive modes of transport have increasingly dominated in recent years. In England, schemes to encourage people to opt for more physically active forms of travel (such as walking and cycling) are 'patchy'.

Policy goal

Ensure government funding supports physically active modes of travel.

To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 9 (see also recommendation 21)

What action should be taken?

- Ensure guidance for local transport plans supports physically active travel. This can be achieved by allocating a percentage of the integrated block allocation fund to schemes which support walking and cycling as modes of transport.
- Create an environment and incentives which promote physical activity, including physically active travel to and at work.
- Consider and address factors which discourage physical activity, including physically active travel to and at work. An example of the latter is subsidised parking.

Public sector catering guidelines

Public sector organisations are important providers of food and drink to large sections of the population. It is estimated that they provide around one in three meals eaten outside the home. Hence, an effective way to reduce the risk of CVD would be to improve the nutritional quality of the food and drink they provide.

Policy goals

- Ensure publicly funded food and drink provision contributes to a healthy, balanced diet and the prevention of CVD.
- Ensure public sector catering practice offers a good example of what can be done to promote a healthy, balanced diet.

To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 10 (see also recommendations 19 and 20)

What action should be taken?

- Ensure all publicly funded catering departments meet Food Standards Agency-approved dietary guidelines. This includes catering in schools, hospitals and public sector work canteens.
- Assess the effectiveness of the 'Healthier food mark' pilot[10]. If successful, develop a timetable to implement it on a permanent basis.

[10] www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/HealthierFoodMark/index.htm

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Take-aways and other food outlets

Food from take-aways and other outlets (the 'informal eating out sector') comprises a significant part of many people's diet. Local planning authorities have powers to control fast-food outlets.

Policy goal

Empower local authorities to influence planning permission for food retail outlets in relation to preventing and reducing CVD. To achieve this, the following are among the measures that should be considered.

Recommendation 11 (see also recommendations 23 and 24)

What action should be taken?

- Encourage local planning authorities to restrict planning permission for take-aways and other food retail outlets in specific areas (for example, within walking distance of schools). Help them implement existing planning policy guidance in line with public health objectives. (See also recommendation 12.)
- Review and amend 'classes of use' orders for England to address disease prevention via the concentration of outlets in a given area. These orders are set out in the Town and Country Planning (Use Classes) Order 1987 and subsequent amendments.

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Monitoring

CVD is responsible for around 33% of the observed gap in life expectancy among people living in areas with the worst health and deprivation indicators compared with those living elsewhere in England. Independent monitoring, using a full range of available data, is vital when assessing the need for additional measures to address such health inequalities, including those related to CVD.

Policy goal

Ensure all appropriate data are available for monitoring and analysis to inform CVD prevention policy. To achieve this, the evidence suggests that the following are among the measures that should be considered.

Recommendation 12

What action should be taken?

- Ensure data on CVD prevention is available for scrutiny by the public health community as a whole.
- Ensure new econometric data (including pooled consumer purchasing data) are rapidly made available by industry for monitoring and analysis by independent agencies.
- Use population surveys (including the 'National diet and nutrition survey'[11] [NDNS] and the 'Low income diet and nutrition survey'[12] [LIDNS]) and data from all relevant sources to monitor intake of nutrients for all population groups. (Sources include: the Food Standards Agency, Department of Health, Department for Environment, Food and Rural Affairs, Office for National Statistics, the Public Health Observatories, academic and other researchers.)
- Monitor the intake of salt, trans fatty acids, saturated fatty acids and mono and polyunsaturated fatty acids among different population groups and report the findings for those groups.
- Support the 'National diet and nutrition survey' and the 'Low income diet and nutrition survey'.
- Ensure the CVD module (including lipid profile measures) routinely appears in the 'Health surveys for England'[13].
- Develop an international public health information system (resembling GLOBALink[14]) for CVD prevention and use it to ensure widespread dissemination of these data.

[11] www.food.gov.uk/science/dietarysurveys/ndnsdocuments/
[12] www.food.gov.uk/science/dietarysurveys/lidnsbranch/
[13] www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/HealthSurveyForEngland/DH_632
[14] www.globalink.org

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Recommendations for practice

Recommendations 13–18: regional CVD prevention programmes

Recommendations 13–18 provide for a comprehensive regional and local CVD prevention programme. They should all be implemented, following the order set out below and in conjunction with recommendations 1–12, which they support. The aim is to plan, develop and maintain effective programmes.

The target population for recommendations 13–18 and the list of who should take action is outlined below. This is followed by the specific actions to be taken in relation to each element of the programme.

Whose health will benefit?

The population that falls within a local authority, primary care trust (PCT) area or across combined PCT and local authority areas or within a particular region of the country.

Who should take action?

Commissioners and providers of public health intervention programmes within:

- city region partnerships
- government regional offices
- local authorities
- local strategic partnerships
- non-governmental organisations, including charities and community groups
- PCTs
- strategic health authorities.

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Recommendation 13 Good practice principles

What action should be taken?

- Ensure a CVD prevention programme comprises intense, multi-component interventions.
- Ensure it takes into account issues identified in recommendations 1 to 12.
- Ensure it includes initiatives aimed at the whole population (such as local policy and regulatory initiatives) which complement existing programmes aimed at individuals at high risk of CVD.
- Ensure it is sustainable for a minimum of 5 years.
- Ensure appropriate time and resources are allocated for all stages, including planning and evaluation.

Recommendation 14 Preparation

What action should be taken?

- Gain a good understanding of the prevalence and incidence of CVD in the community. Find out about any previous CVD prevention initiatives that have been run (including any positive or negative experiences).
- Consider how existing policies relating to food, tobacco control and physical activity, including those developed by the local authority, may impact on the prevalence of CVD locally.
- Gauge the community's level of knowledge of, and beliefs about, CVD risk factors. This includes beliefs that smoking is the only solace in life for people with little money, or that only people who have a lot of money eat salad.
- Gauge how confident people in the community are that they can change their behaviour to reduce the risks of CVD. (See 'Behaviour change' [NICE public health guidance 6].)
- Identify groups of the population who are disproportionately affected by CVD and develop strategies with them to address their needs.
- Take into account the community's exposure to risk factors (factors currently facing adults and those emerging for children and younger people).

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Recommendation 15 Programme development

What action should be taken?

- Develop a population-based approach.
- Ensure a 'programme theory' is developed and used to underpin the programme[15]. This should cover the reasons why particular actions are expected to have particular outcomes.
- Ensure the programme helps address local area agreement targets and acts as a local incentive for world class commissioning in the NHS[16]. Also ensure it tackles health inequalities.
- Link the programme with existing strategies for targeting people at particularly high risk of CVD and take account of ongoing, accredited screening activities by GPs and other healthcare professionals. This includes the NHS Health Checks programme[17].
- Work closely with regional and local authorities and other organisations to promote policies which are likely to encourage healthier eating, tobacco control and increased physical activity. Policies may cover spatial planning, transport, food retailing and procurement. Organisations that may get involved could include statutory, public sector and civil society groups (examples of the latter are charities, clubs, self-help and community groups).
- When developing CVD programmes, take account of relevant recommendations made within the following NICE guidance:
  - 'Brief interventions and referrals for smoking cessation' (NICE public health guidance 1)
  - 'Four commonly used methods to increase physical activity' (NICE public health guidance 2)
  - 'Workplace interventions to promote smoking cessation' (NICE public health guidance 5)
  - 'Behaviour change' (NICE public health guidance 6)
  - 'Physical activity and the environment' (NICE public health guidance 8)
  - 'Community engagement' (NICE public health guidance 9)
  - 'Smoking cessation services' (NICE public health guidance 10)
  - 'Maternal and child nutrition' (NICE public health guidance 11)
  - 'Promoting physical activity in the workplace' (NICE public health guidance 13)
  - 'Identifying and supporting people most at risk of dying prematurely' (NICE public health guidance 15)
  - 'Physical activity and children' (NICE public health guidance 17)
  - 'Obesity' (NICE clinical guideline 43).
- Only develop, plan and implement a strategic, integrated media campaign as part of a wider package of interventions to address CVD risk factors. Media campaigns should be based on an acknowledged theoretical framework.

[15] Pawson R (2001) Evidence based policy: 2. The promise of 'realist synthesis' [online]. Available from http://evi.sagepub.com/cgi/content/abstract/8/3/340

[16] www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm

[17] www.improvement.nhs.uk/nhshealthcheck/

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Recommendation 16 Resources

What action should be taken?

- Ensure the programme lasts a minimum of 5 years (while subject to annual evaluation reports) to maximise its potential impact.
- Produce a long-term plan – and gain political commitment – for funding to ensure the programme has adequate resources and is sustainable beyond the end of the research or evaluation period.
- Ensure the programme is adequately staffed. Avoid adding CVD prevention to the workload of existing staff without relieving them of other tasks.
- Ensure volunteers are an additional (rather than a core) resource and that their training and support is adequately resourced.
- Ensure steps are taken to retain staff.
- Where staff are recruited from the local community ensure, as far as possible, that they reflect the local culture and ethnic mix.
- Ensure there are effective links with other existing and relevant community initiatives.

Recommendation 17 Leadership

What action should be taken?

- Act as leader and governor of CVD prevention. Identify and articulate local community needs and aspirations and how these may impact on the community's risk of CVD. Reconcile these needs and aspirations or arbitrate on them to help prevent CVD[18].
- Identify senior figures within PCTs and local authorities as champions for CVD prevention.
- Identify people to lead the CVD programme, including members of the local community. Identify in advance – and provide for – the training and other needs of these potential leaders.
- Develop systems within local strategic partnerships and other subregional or regional partnerships for agreeing shared priorities with other organisations involved in CVD prevention. Ensure senior staff are involved, as appropriate.

[18] HM Government; Communities and Local Government (2008) Creating strong, safe and prosperous communities. Statutory guidance. London: Community and Local Government Publications.

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Recommendation 18 Evaluation

What action should be taken?

- Establish baseline measures before the CVD programme begins. These should include lifestyle and other factors that influence cardiovascular risk, as well as figures on CVD prevalence and mortality. The establishment of such measures should be budgeted for as part of the programme.
- Ensure evaluation is built in (in line with 'Behaviour change' [NICE public health guidance 6]). It should include the policies and activities of partner organisations which are likely to influence CVD prevalence.
- Ensure appropriate methods (using multiple approaches and measures) are used to evaluate the programme's processes, outcomes and measures or indicators. Evaluation should include determining how acceptable the programme is to the local community or the groups targeted.
- Ensure the results of evaluation are freely available and shared with partner organisations. Use the findings to inform future activities.

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Recommendation 19 Children and young people

Whose health will benefit?

Children and young people aged under 16 years.

Who should take action?

- Parents and carers of children and young people under the age of 16.
- Local authorities (providers of cultural and leisure services).
- Schools (governors and teachers).
- Catering staff.
- Nursery nurses and workers in pre-school day care settings such as nurseries.
- Managers of children's centres.

What action should they take?

- Help children and young people to have a healthy diet and lifestyle. This includes helping them to develop positive, life-long habits in relation to food. 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. (For more details see 'Maternal and child nutrition' [NICE public health guidance 11] and 'Physical activity and children' [NICE public health guidance 17].)
- When public money is used to procure food and drink in venues outside the direct control of the public sector, ensure those venues provide a range of affordable healthier options (including from vending machines). Ideally, the healthier options should be cheaper than the less healthy alternatives. For instance, carbonated or sweetened drinks should not be the only options and fruit and water should be available at an affordable price. (Examples of when public money is used in this way include school visits to museums, sports centres, cinemas and fun parks.)
- Encourage venues frequented by children and young people and supported by public money to resist sponsorship or product placement from companies associated with foods high in fat, sugar or salt. (This includes fun parks and museums.)
- Organisations in the public sector should avoid sponsorship from companies associated with foods high in fat, sugar or salt.

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Recommendation 20 Public sector food provision

Whose health will benefit?

Anyone who eats food provided by public sector organisations.

Who should take action?

- Education authorities.
- Government departments and agencies.
- Local authorities.
- NHS organisations.
- Prison services.
- The armed forces.
- The emergency services.

What action should they take?

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'[19]
- does not contain industrially produced trans fatty acids (IPTFAs).

Recommendation 21 Physical activity

Whose health will benefit?

Everyone.

Who should take action?

- Local authorities.
- PCTs.

What action should they take?

- Ensure the physical environment encourages people to be physically active (see 'Physical activity and the environment' [NICE public health guidance 8]). Implement changes where necessary. This includes prioritising the needs of pedestrians and cyclists over motorists when developing or redeveloping highways. It also includes developing and implementing public sector workplace travel plans that incorporate physical activity (see 'Promoting physical activity in the workplace' [NICE public health guidance 13]). Encourage and support employers in other sectors to do the same.
- Ensure the need for children and young people to be physically active is addressed (see 'Promoting physical activity for children and young people' [NICE public health guidance 17]). This includes providing adequate play spaces and opportunities for formal and informal physical activity.
- Audit bye-laws and amend those that prohibit physical activity in public spaces (such as those that prohibit ball games).
- Consider offering free swimming to parents and carers who accompany children aged under 5 years to swimming facilities.

(Continued on page 24)

[19] Food Standards Agency (2007) Eatwell plate [online]. Available from www.eatwell.gov.uk/healthydiet/eatwellplate/

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(Continued from page 23)

- Apportion part of the local transport plan (LTP) block allocation to promote walking, cycling and other forms of travel that involve physical activity. The proportion allocated should be in line with growth targets for the use of these modes of transport.
- Ensure cycle tracks created under the Cycle Tracks Act 1984 are part of the definitive map (the legal record of public rights of way).
- Align all 'planning gain' agreements with the promotion of heart health to ensure there is funding to support physically active travel. (For example, Section 106 agreements are sometimes used to bring development in line with sustainable development objectives[20].)

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

Whose health will benefit?

Everyone.

Who should take action?

- Local policy makers.
- PCTs.
- Regional and local government.

What action should they take?

- Use a variety of methods to assess the potential impact (positive and negative) that all local and regional policies and plans may have on rates of CVD and related chronic diseases. Take account of any potential impact on health inequalities.
- Identify those policies and plans that are likely to have a significant impact on CVD rates. This can be achieved by using screening questions that cover the social, economic and environmental determinants of CVD.
- Monitor the outcomes following an assessment and use this to follow up and amend plans.
- Identify where expertise is required to carry out assessments and where this is available locally.
- Identify the training and support needs of staff involved in carrying out assessments and provide the necessary resources.

[20] www.communities.gov.uk/planningandbuilding/planning/planningpolicyimplementation/planningobligations/modelplanningobligation/

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Recommendation 23 Take-aways and other food outlets

Whose health will benefit?

Everyone but particularly those who frequently use these food outlets.

Who should take action?

- Environmental health officers.
- Local government planning departments.
- Public health nutritionists.
- Trading standards officers.

What action should they take?

- Use bye-laws to regulate the opening hours of take-aways and other food outlets, particularly those near schools that specialise in foods high in fat, salt or sugar.
- Use existing powers to set limits for the number of take-aways and other food outlets in a given area. Directives should specify the distance from schools and the maximum number that can be located in certain areas.
- Help owners and managers of take-aways and other food outlets to improve the nutritional quality of the food they provide. This could include monitoring the type of food for sale and advice on content and preparation techniques.

Recommendation 24 Nutrition training

Whose health will benefit?

People eating snacks and meals provided by public sector services.

Who should take action?

- Caterers.
- Chartered Institute of Environmental Health (CIEH).
- Local authorities.
- Providers of hygiene training.
- The food and farming network (Feast).

What action should they take?

- Ensure the links between nutrition and health are an integral part of training for catering managers. In particular, they should be made aware of the adverse effect that frying practices and the use of salt, industrial trans fats and saturated fats can have on health.
- Ensure they are aware of the healthy alternatives to frying and to using salt and sugar excessively, based on the 'eatwell plate'[21].

[21] Food Standards Agency (2007) Eatwell plate [online]. Available from www.eatwell.gov.uk/healthydiet/eatwellplate/

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Implementation tools

NICE has developed tools to help organisations put this guidance into practice. For details see our website at www.nice.org.uk/guidance/PH25

Further information

You can download the following from www.nice.org.uk/guidance/PH25

- A quick reference guide (this document) for professionals and the public.
- The guidance – the recommendations, details of how they were developed and evidence statements.
- Details of all the evidence that was considered and other background information.

For printed copies of the quick reference guide, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote N2197.

The NICE website has a screen reader service called Browsealoud which allows you to listen to our guidance. Click on the Browsealoud logo on the NICE website to use this service.

Updating the recommendations

This guidance will be reviewed at 3 and 5 years after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted at www.nice.org.uk/guidance/PH25

Related NICE guidance

For more information about NICE guidance that has been issued or is in development, see www.nice.org.uk

- Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010). Available from www.nice.org.uk/guidance/PH24
- Promoting physical activity for children and young people. NICE public health guidance 17 (2009). Available from www.nice.org.uk/guidance/PH17
- Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. NICE clinical guideline 67 (2008). Available from www.nice.org.uk/guidance/CG67
- 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

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- Community engagement. NICE public health guidance 9 (2008). Available from www.nice.org.uk/guidance/PH9
- 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 referral for smoking cessation in primary care and other settings. NICE public health guidance 1 (2006). Available from www.nice.org.uk/guidance/PH1
- Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43 (2006). Available from www.nice.org.uk/guidance/CG43
- Hypertension: management of hypertension in adults in primary care. NICE clinical guideline 34 (2006). Available from www.nice.org.uk/guidance/CG34

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