NICE Update
NICE public health guidance update

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What’s new?

The following two pieces of guidance have been published during May and June 2010.

- Alcohol-use disorders: preventing the development of hazardous and harmful drinking (http://guidance.nice.org.uk/PH24).

These are profiled below, together with the recently published guidance on school-based interventions to prevent smoking (http://guidance.nice.org.uk/PH23).

Guidance on the prevention of cardiovascular disease at the population level

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.

Changes in risk factors for cardiovascular disease can be brought about by interventions at various levels. This guidance focuses on population-based approaches. These are interventions that aim to change the risks relating to social, economic, material and environmental factors that affect an entire population. This can be achieved through regulation, legislation, subsidy and taxation or rearranging the physical layout of communities. The guidance complements the NHS Health Check programme.

Certain cardiovascular disease risk factors, such as tobacco use, obesity and physical activity have already been the topic of other NICE guidance. This guidance focuses on salt, saturated fats and trans fatty acids. Addressing cardiovascular disease risk factors will also help reduce a wide range of other chronic conditions, such as type 2 diabetes and many common cancers.

Recommendations 1–12 identify a range of policy goals providing 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 the population level.

The policy recommendations address salt, saturated fats, industrially produced transfats (IPTFA), marketing aimed at children and young people, commercial interests, labeling, health impact assessment, the Common Agricultural Policy, physically active travel, public sector catering guidelines, takeaways and other food outlets and monitoring. As well as 12 policy goal recommendations, the guidance contains 12 recommendations for practice. These include recommendations for comprehensive regional and local CVD prevention programmes. The recommendations for practice are supported by, and support, the policy-level recommendations.

The financial modelling for the guidance shows that considerable cost savings could be made. Using a number of conservative assumptions, it found that halving CVD events across England and Wales would result in discounted savings in healthcare costs of approximately £14 billion per year. Reducing mean population cholesterol or blood pressure levels by 5% would result in discounted annual savings of approximately £0.7 and £0.9 billion, respectively. Reducing population cardiovascular risk by even 1% would generate discounted savings of approximately £260 million per year. A 3 g reduction in mean daily salt intake by adults (to achieve a target of 6 g daily) would lead to around 14–20 000 fewer deaths from CVD annually. Using conservative assumptions, this means approximately £350 million in...
healthcare costs would be saved. In addition, approximately 130 000 quality-adjusted life years (QALYs) would be gained. A mean reduction of 6 g per day would double the benefits: an annual saving of £700 million in healthcare costs and a gain of around 260 000 QALYs. A 3 g reduction in daily salt intake (a reasonably conservative estimate of what could be achieved) would reduce systolic blood pressure by approximately 2 mmHg. This would equate to a 2% decrease in the risk reduction model. Similarly, a reduction of IPTFA intake to approximately 0.7% of total fat energy might save approximately 571 000 life years, and some £2 billion.

**Alcohol-use disorders: preventing the development of hazardous and harmful drinking**

This is one of three pieces of NICE guidance addressing alcohol problems among people aged 10 years and older. The others are: alcohol-use disorders in adults and young people: clinical management and alcohol dependence and harmful use: diagnosis and management in young people and adults.

This public health guidance is for government, industry and commerce, the NHS, local authorities and education—and all those others whose actions affect the population’s attitude to—and use of alcohol.

The recommendations include a number of policy changes relating to price, availability and marketing of alcohol. Importantly, government should consider introducing a minimum price per unit of alcohol. The evidence shows that making alcohol less affordable is the most effective way of reducing alcohol-related harm. The guidance does not state a specific minimum price per unit of alcohol but recommends a level is set by taking into account the health and social costs of alcohol-related harm and its impact on alcohol consumption. Consideration should also be given to revising legislation on licensing to ensure protection of the public’s health is one of its objectives, and to ensure that licensing departments can take into account the number of alcohol outlets in a given area and times alcohol can be sold. Measures are also recommended for strengthening and enforcement measures relating to prevention of under-aged sales. A review of the current advertising codes is proposed to ensure that children and young people’s exposure to alcohol advertising is as low as possible.

The guidance also covers commissioning and provision of screening and brief interventions and referral. Commissioners should ensure plans that include screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and for those health is being damaged by alcohol (harmful drinkers). The specification of services covers:

- Support for children and young people aged 10–15 years.
- Screening young people aged 16 and 17 years thought to be at risk from their use of alcohol, and extended brief interventions for those who have been identified via screening as drinking hazardous or harmfully.
- Screening of adults focusing on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition, and brief interventions for those identified via screening, and extended brief interventions for those who have not responded to brief interventions or could benefit from extended brief interventions for other reasons.

Many of those working in public services have contact with people who are drinking a hazardous or harmful amount. These health professionals and professionals working in other areas (such as social care, criminal justice, higher education, occupational health and children’s services) are well placed to provide these interventions.

A business case report accompanies the guidance. This examined the costs associated with alcohol use disorders and potential savings achievable by implementing the guidance recommendations aimed at preventing the development of hazardous and harmful drinking. The current cost of alcohol harm is estimated at £12.6 billion (comprising healthcare costs, crime and antisocial behaviour and employee absenteeism). (It should be noted that this figure does not cover the full total costs to the economy of alcohol-related harm.) For the purpose of the analysis a minimum unit cost of £0.40 per unit of alcohol was assumed, and the estimated potential savings of introducing this minimum price is £82.5 million. The estimated potential savings of reducing the number of alcohol outlets is estimated at £105.3 million, and reducing licensing hours at £53.7 million. While screening and brief interventions could incur substantial additional costs the estimated reduction in alcohol intake would result in savings for the NHS.

**School-based interventions to prevent smoking**

Early this year the government published a new tobacco control strategy for England, A Smokefree Future, to update the earlier White Paper, Smoking Kills (1998). The
comprehensive tobacco control strategy introduced in 1998 has been very successful, with the number of adult smokers falling by a fifth and the number of children taking up the habit halved in the last decade.\(^1\)

The new strategy has three key objectives, the first of which is to stop young people being recruited into smoking. Essential to this are major elements of a tobacco control policy that affect both adults and children—smoke-free public places, increasing the real price of tobacco, ending all forms of tobacco promotion and increasing awareness of the harm done by tobacco. For children and young people, schools and other educational establishments have a special role to play in reinforcing their understanding of all the consequences of tobacco production and use.

School-based interventions to prevent smoking will be useful for all those responsible for preventing the uptake of smoking by children and young people aged under 19. This includes those working in the NHS, local authorities, education and the wider public, private, voluntary and community sectors. It may also be of interest to children and young people, their parents or carers and other members of the public.

For the purposes of the guidance, ‘schools’ include ‘extended schools’ (where childcare or informal education is provided outside school hours), pupil referral units, secure training and local authority secure units. It also includes further education colleges. The five recommendations include the following advice.

- The smoking policy should support both prevention and stop smoking activities and should apply to everyone using the premises (including the grounds).
- Information on smoking should be integrated into the curriculum. For example, classroom discussions could be relevant when teaching biology, chemistry, citizenship and maths.
- Anti-smoking activities should be delivered as part of personal, social, health and economic and other activities related to healthy schools or healthy further education status.
- Anti-smoking activities should aim to develop decision-making skills and include strategies for enhancing self-esteem. Parents and carers should be encouraged to get involved and students could be trained to lead some of these programmes.
- All staff involved in smoking prevention should be trained to do so.
- Educational establishments should work in partnership with outside agencies to design, deliver, monitor and evaluate smoking prevention activities.

References