Scottish Briefing on NICE public health guidance 30:

Preventing unintentional injuries in the home among children and young people aged under 15: home safety assessments and providing safety equipment

This Scottish Briefing presents the action recommendations and underpinning evidence base from the above public health guidance, produced for England by the National Institute for Health and Clinical Excellence (NICE) and published in November 2010 (available at www.nice.org.uk/ph30). For convenience, electronic links are provided between the recommendations and their related evidence.

The purpose of this Scottish Briefing is to raise awareness of the NICE guidance in Scotland, and to help relevant individuals and organisations identify appropriate action, where applicable, in Scottish national and local contexts. As part of the latter, electronic links to identified relevant Scottish material are provided.

Users should read the important notes on page 13.

Contents

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Prioritising households at greatest risk</td>
<td>3</td>
</tr>
<tr>
<td>2 – Working in partnership</td>
<td>4</td>
</tr>
<tr>
<td>3 – Coordinated delivery</td>
<td>5</td>
</tr>
<tr>
<td>4 – Follow-up on home safety assessments and interventions</td>
<td>6</td>
</tr>
<tr>
<td>5 – Integrating home safety into other home visits</td>
<td>6</td>
</tr>
</tbody>
</table>

| Evidence                                             | 7    |

| Relevant Scottish links                              | 13   |

| Important notes for users                            | 13   |

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Recommendations

Context
NICE public health guidance 30 states that the recommendations contained within the guidance should be implemented as part of a broader strategy to reduce unintentional injuries in the home. This would include the use of regulations and the provision of safety education to prevent such injuries. (Note that in November 2010, NICE published public health guidance 29, which provides guidance on strategies, regulation, enforcement, surveillance and workforce development to prevent unintentional injuries [see www.nice.org.uk/guidance/PH29].)

NICE public health guidance 30 focuses on home safety assessments and the supply and installation of home safety equipment, either delivered separately or together. It also covers education and advice when delivered as part of these interventions.

Implementation of all the recommendations should ensure a systematic approach can be adopted. This involves prioritising households at greatest risk of unintentional injuries and establishing partnerships to ensure coordinated delivery and follow-up on home safety assessments and equipment interventions. In addition, the recommendations make the consideration of home safety issues a part of routine practice for all practitioners visiting children and young people at home.

Note on definitions used
NICE public health guidance 30 uses the term ‘unintentional injuries’ rather than ‘accidents’. It points out that the term ‘accident’ implies an unpredictable and therefore, unavoidable event, and cites Davis and Pless (BMJ 2001; 322: 1320-21) as stating that ‘most injuries and their precipitating events are predictable and preventable’.

A home safety assessment is defined as the process of systematically identifying potential hazards in the home, evaluating the risks and providing information or advice on how to reduce them. Other terms commonly used to describe the same process include ‘home risk assessment’ and ‘home safety check’. It may be carried out by a trained assessor or by parents and other householders, using an appropriate checklist. [Home safety assessment tools are available from The Royal Society for the Prevention of Accidents (www.rospa.com ) and SafeHome (www.safehome.org.uk )]

In this guidance, home safety equipment is any device used to prevent injury in the home. This includes door guards and cupboard locks, safety gates and barriers, smoke and carbon monoxide alarms, thermostatic mixing valves and window restrictors.

For the purposes of this NICE public health guidance 30, ‘home’ refers to inside the dwelling itself. It does not include the garden or outbuildings.

Whose health will benefit?
The recommendations aim to help children and young people aged under 15 years who are at greatest risk of an unintentional injury and their parents and carers. In particular, it is aimed at those living in disadvantaged circumstances.
Recommendation 1 –
Prioritising households at greatest risk
(Evidence: economic modelling; IDE)

Who should take action?

- Local safeguarding children boards.
- Local authority children’s services and their partnerships.
- Local strategic partnerships.
- Local authority health and wellbeing boards and partnerships (where they are not part of the local strategic partnership).

What action should they take?

- Determine the types of household where children and young people aged under 15 are at greatest risk of unintentional injury based on surveys, needs assessments and existing datasets (such as local council housing records).
- Prioritise the households identified above for home safety assessments and the supply and installation of home safety equipment (see Recommendations 2 and 3). ‘Priority households’ could include those with children aged under 5, families living in rented or overcrowded conditions or families living on a low income. It could also include those living in a property where there is a lack of appropriately installed safety equipment, or one where hazards have been identified through the Housing Health and Safety Rating System (HHSRS) [The Housing Health and Safety Rating System (HHSRS) is a risk assessment procedure for residential properties. Available from www.communities.gov.uk].
- Provide practitioners who visit children and young people at home with mechanisms for sharing information about households that might need a home safety assessment. [An example might include the common assessment framework (CAF).] This includes health visitors, social workers and GPs.
- Ensure practitioners adhere to good practice on maintaining the confidentiality and security of personal information. (For example, this includes using end-to-end encryption when sharing data with other agencies.) [See for example, HM Government (2008) Information sharing: guidance for practitioners and managers. London: Department for Children, Schools and Families and Communities and Local Government. Available from www.education.gov.uk/publications]
Recommendation 2 – Working in partnership
(Evidence: B4, B5, B6, B8, B9, B11, B12, B13, B14, B15; IDE)

Who should take action?
- Strategic planners and leads with responsibility for child health.
- Fire and rescue services.
- Housing associations.
- Local authorities: leads for children’s services, environmental health, accident prevention and home safety and housing.
- Sure Start and children’s centres.

What action should they take?
- Establish local partnerships with relevant statutory and voluntary organisations or support existing ones. Partners could include:
  - local community and parent groups
  - organisations employing health and social practitioners who visit children and young people in their homes (for example, health visitors)
  - child care agencies
  - others with a remit to improve the health and wellbeing of children aged under 15
  - local umbrella organisations for private and social landlords
  - those involved in lifestyle and other health initiatives.
- Use these partnerships to:
  - help collect information on specific households where children and young people aged under 15 may be at greatest risk of an unintentional injury (see Recommendation 1). The collection and sharing of information should adhere to the standards referred to in Recommendation 1
  - help determine and address barriers to creating a safe home environment. (For example, the cost of equipment, cultural norms, issues of trust or a lack of control over the home environment may all be barriers to installing safety equipment)
  - get the community involved (as outlined in NICE public health guidance 9 ‘Community engagement’). For example, local ‘community champions’ could be used to promote home safety interventions and help practitioners gain the trust of householders
  - carry out home safety assessments and supply and install home safety equipment, in line with Recommendation 3. [Home safety assessment tools are available from The Royal Society for the Prevention of Accidents (www.rospa.com ) and SafeHome (www.safehome.org.uk ).]
**Recommendation 3 – Coordinated delivery**  
(Evidence: E2a, E2b, E3b, E3c, E3d, E4b, E4c, E4d, E6b, E7b, E9b, B3, B4, B5, B6, B7, B8, B9, B10, B11, B12, B13, B14, B15; IDE)

Who should take action?
- Those who carry out home safety assessments and provide home safety equipment (see Recommendation 2).

What action should they take?
- Offer home safety assessments to the households prioritised in Recommendations 1 and 2 [See for example, HM Government (2008) Information sharing: guidance for practitioners and managers. London: Department for Children, Schools and Families and Communities and Local Government. Available from www.education.gov.uk/publications.] Where appropriate, supply and install suitable, high quality home safety equipment. Home safety equipment should adhere to the British ‘Kite mark’ standards or the equivalent European standard. Where resources are limited, it may be necessary to narrow down further the households being prioritised (for example, to those with children under the age of 5 years).
- Ensure the assessment, supply and installation of equipment is tailored to meet the household’s specific needs and circumstances. Factors to take into account include:
  - the developmental age of the children (in relation to any equipment installed)
  - whether or not a child or family member has a disability
  - cultural and religious beliefs
  - whether or not English is the first language
  - levels of literacy
  - the level of control people have over their home environment (Many people may not have the authority to agree to an installation, for example, tenants of social and private landlords and those who are unable to make household or financial decisions.)
  - the household’s perception of, and degree of trust in, authority.
- Ensure education, advice and information is given during a home safety assessment, and during the supply and installation of home safety equipment. This should emphasise the need to be vigilant about home safety and explain how to maintain and check home safety equipment. It should also explain why safety equipment has been installed – and the danger of disabling it. In addition, useful links and contacts should be provided in case of a home safety problem.
Recommendation 4 –
Follow-up on home safety assessments and interventions
(Evidence: B3; economic modelling, IDE)

Who should take action?
- Those who carry out home safety assessments and provide home safety equipment (see Recommendations 2 and 3).

What action should they take?
- Prevent duplication of effort by keeping a record of households that have been given safety advice or equipment. (It may be possible to use an existing local database.) Ensure the records are accessible to all those with a direct or indirect responsibility for preventing unintentional injuries in the home.
- Adhere to the standards referred to in Recommendation 1 in relation to the collection and sharing of information.
- Use the records to identify when maintenance and follow-up are required, to feed into strategic planning and to prioritise future interventions (see Recommendation 1).
- Contact homes identified as being in need of an equipment maintenance check or follow-up. Offer to revisit them to see if the equipment is still appropriate and functional (and in case of a product recall or faults). Ascertain whether there are any new requirements (for example, due to changes in the building or the family). Reinforce home safety messages during these visits.

Recommendation 5 –
Integrating home safety into other home visits
(Evidence: E3e, E3f, E3h, E4b, B2, B9; IDE)

Who should take action?
Practitioners who visit families and carers with children and young people aged under 15. This includes GPs, midwives, social workers and health visitors.

What action should they take?
- Recognise the importance of measures to prevent unintentional injuries in the home among children and young people aged under 15, particularly among those living in disadvantaged circumstances.
- Provide child-focused home safety advice. If the family or carers agree, refer them to agencies that can undertake a home safety assessment and can supply and install home safety equipment.
- Encourage parents, carers and others living with children and young people aged under 15 to conduct their own home safety assessment. They should use an appropriate tool, as outlined in Recommendation 3.
Evidence

Notes:
1. The numbered evidence statements presented here were derived from the reviews indicated and are those that are cited in the NICE guidance in relation to one or more of the action recommendations (as shown below). The symbols ‘++’, ‘+’, ‘–’ and ‘u’ indicate the assessed quality of reviewed studies: ‘++’ = highest quality; ‘–’ = lowest; ‘u’ = unclear. Other evidence statements are available in the full evidence review reports, at www.nice.org.uk/ph30
2. In addition, economic modelling was used to explore the potential cost-effectiveness of a selection of home based interventions which have a primary or significant purpose of reducing injuries in the home. This is available at www.nice.org.uk/ph30 (See Recommendations 1 and 4)
3. In the guidance, where a recommendation was inferred from the evidence, this is indicated by ‘IDE’ (inference derived from the evidence). (See Recommendations 1, 2, 3, 4 and 5)

Evidence Statements

From Review 1
(‘Preventing unintentional injuries among under-15s in the home. Systematic reviews of effectiveness and cost-effectiveness of home safety equipment and risk assessment schemes.’)

- E2a – There is inconsistent evidence about impact on injury from one cluster randomised controlled trial (RCT) (++) and one controlled before-and-after study (CBA) (+). There is evidence from the better quality cluster RCT that the free supply and installation of smoke alarms had no significant effect on the incidence of fire-related hospitalisations and deaths (rate ratio 1.0 [95% confidence interval (CI) 0.5, 2.0]). However, the CBA study suggests that the free supply and installation of smoke alarms decreased the incidence of fire-related injuries (within-group pre-post intervention comparison: 0.2 [95% CI 0.1, 0.4] for the intervention group and 1.1 [95% CI 0.7, 1.7] for the remainder of the city). (See Recommendation 3)

- E2b – There is inconsistent evidence about impact on rates of installation of home safety equipment from two cluster RCTs (one [++], one [+]) and one CBA (+). There is evidence from the better quality cluster RCT that the free supply and installation of smoke alarms had no significant effect on the installation or functioning of smoke alarms within households (Rate ratio 1.0 [95% CI 0.4, 2.4]). However, there is evidence from the other cluster RCT that the free supply and installation of smoke alarms had a significant effect on the installation and functioning of smoke alarms: odds ratio (OR) 4.82 (95% CI 3.97, 5.85). The CBA study reported that 51% of intervention households (identified as being without a smoke alarm prior to the intervention) had a correctly installed and functioning smoke alarm at 12 months follow-up. (See Recommendation 3)

(contd over)
- E3b – There is moderate evidence from three RCTs (one [++] one [+] and one [-]) that the free or discounted supply of smoke alarms in conjunction with safety education increases the rate of installation of these devices. (See Recommendation 3)
- E3c – There is weak evidence from two RCTs (one [++] and one [+]) about interventions with free or discounted supply of home safety equipment in conjunction with safety education. Outcomes about three types of home safety equipment (buffers, electrical outlet covers and cupboard locks/latches) are reported, showing mixed evidence of effect. Outcomes about other types of home safety equipment (non-slip bathroom items, window locks, fire guards and stair gates) are presented in one report, with only fire guards reported as being more likely to be present post-intervention (based on self-report). (See Recommendation 3)
- E3d – There is weak evidence from one RCT (++) that the free or discounted supply of a range of safety equipment, in conjunction with safety education, increases the rate of installation of safety equipment as a whole (mean difference [MD] 21.1 [95% CI 13.90, 28.30]) (based on self-report). (See Recommendation 3)
- E3e – There is strong evidence from four RCTs (two [++], one [+] and one [-]) that the free or discounted supply of a range of safety equipment, in conjunction with safety education, increases knowledge about the prevention of poisoning and scalds. (See Recommendation 4)
- E3f – There is inconsistent evidence from three RCTs (two [++] and one [+]) about how a free or discounted supply of a range of safety equipment, in conjunction with safety education, affects knowledge about: the prevention of fires, falls and wounds. (See Recommendation 5)
- E3h – There is weak evidence from one RCT (+) that the free or discounted supply of a range of safety equipment, in conjunction with safety education, increases knowledge about the prevention of suffocation. (See Recommendation 5)
- E4b – There is weak evidence from one RCT (++) that free home safety equipment (or its delivery) and installation with safety education increases the use of smoke alarms at 12 months (OR 1.83 [95% CI 1.33, 2.53]) and 24 months (OR 1.67 [95% CI 1.21, 2.32]). The intervention did not have a statistically significant impact on reducing socioeconomic inequalities in the uptake and continued use (12 months post-intervention) of smoke alarms. (See Recommendations 3 and 5)
- E4c – There is weak evidence from one RCT (++) that showed mixed evidence of effect of the supply of free home safety equipment (or its delivery) and installation with safety education. Outcomes showed no impact on fire guards being fitted and always used after 12 or 24 months, and increased use of stair gates and window locks at 12 months, but not 24 months. The intervention had a statistically significant impact on reducing socioeconomic inequalities in the uptake and continued use (12 months post-intervention) of stair gates. (See Recommendations 3)
- E4d – There is weak evidence from one RCT (++) that free home safety equipment (or its delivery) and installation with safety education may increase the safe storage at 12 months of cleaning products and sharp objects, but these effects are no longer seen after 24 months for safe storage of sharp objects. (See Recommendation 3)
- E6b – There is inconsistent evidence from two RCTs (one [+] and one [++] ) and one CBA (+) about interventions with a home-risk assessment and free or discounted supply of home safety equipment that included a smoke alarm. Outcomes about the rates of installation of smoke alarms (all self-reported) show mixed evidence of effect (no effect, increased, increased). (See Recommendation 3)

(contd over)
- E7b – Three studies (one CBA [+] and two before-and-after [BA] [{-}, {+}]) report on the continued presence and use of installed equipment after home-risk assessment and free or discounted supply and installation of home safety equipment. There is mixed evidence about the impact on continued working equipment. One study found that 60% of installed hot water tempering valves remained in situ after 6 to 9 months. One study found significant improvements in the numbers of households with working window guards and fire extinguishers post-intervention. Finally, two studies (one CBA [+] and one BA [+]) showed significantly more smoke alarms installed and working post-intervention (p<0.0001; OR 0.30 [95% CI 0.24, 0.38: showing less alarm absence in the intervention group]). (See Recommendation 3)

- E9b – There is inconsistent evidence from six robust studies (which use both observed outcome measures and a controlled study design) about the presence of functional smoke alarms. Four suggest that the intervention increased functioning presence (one RCT [+], one CBA [+], one RCT [-] and one CBA [+]) and two suggest that no significant impact was seen on smoke alarms (both RCT [++]). (See Recommendation 3)

From Review 2
('Barriers to, and facilitators of the prevention of unintentional injury in children in the home: a systematic review of qualitative research.‘)

- B2 – Three studies (three [-]) found that parents felt there was a lack of information or knowledge about existing policies or support. Examples included lack of knowledge of poison centre telephone number, and lack of ‘direct information’ on poisoning prevention. A lack of communication about programmes to install smoke alarms limited uptake, especially for the most high-risk families (those in rented accommodation with a rapid turnover of tenants). Timing of information was shown to be important. One study found that parents given information in hospital, at the time of a child’s birth, did not retain this, while information provided subsequently in a community or physician setting was better retained. (See Recommendation 5)

- B3 – Three studies (all [-]) found that partnerships and collaborations between different service providers facilitated the effectiveness of interventions to reduce unintentional injuries to children in low income communities. Collaborations perceived as useful included multi-agency partnerships between different agencies, and between agencies and hard-to-reach groups. These collaborations aided the effectiveness of a UK smoke alarm installation programme and a partnership between health officials and low income mothers in home safety visits offering advice and provision of safety equipment. The importance of devising information and advice in ways that suit the target community (in terms of language, style, examples used) was noted in both of these papers dealing with low income populations with many ethnic minorities. (See Recommendations 3 and 4)

- B4 – Nine studies (four [-], four [+] and one [++]]) found that a major barrier to implementing safety equipment and childproofing a home was living in a home one was not free to modify. (contd over)
The studies found that mothers particularly found a lack of control over their home environment due to living in rented accommodation, and/or with extended family. In rented accommodation, landlords were reported as unresponsive to requests for installation or maintenance of safety equipment. In extended family homes, often in overcrowded situations, young parents often did not have a say in how the home was arranged. Two studies noted that high turnover of tenants in cheap rented accommodation limited the effectiveness of projects to organise effective installation and maintenance. In two studies, having landlords with the ability and eagerness to make repairs led to more effective interventions. (See Recommendations 2 and 3)

- B5 – Four studies (two [-] and two [+] ) found that faulty or poor quality equipment was a barrier to interventions to reduce unintentional injuries to children in the home. For example, mothers resorted to taping over electric sockets when safety plugs were not provided or did not work.

The four studies made recommendations for different or better equipment. Studies recommended the provision of tamper-proof smoke alarms with 10-year batteries, alternatives of sprinkler systems for some populations, smoke alarms with longer lasting batteries, help for fitting alarms, or simpler systems for older residents, and more systematic provision of child-resistant containers. Suspicion by those in vulnerable communities of strangers coming into their homes to assess or install property, and suspicion of ‘free’ offers, needs to be mitigated in successful interventions. (See Recommendations 2 and 3)

- B6 – The two studies on smoke alarm installation (one [+], one [-]) both found that people balance immediate and longer term risks to health and wellbeing when they disable alarms. They were aware that it was less than ideal to disable smoke alarms, but weighed this against other factors, especially the inconvenience and stress of malfunctioning alarms. (See Recommendations 2 and 3)

- B7 – Three studies (one [+] and two [-]) based on evaluation of specific interventions all found that training in installation and equipment use/replacement was a facilitator to reducing the incidence of unintentional injuries to children in the home. (See Recommendations 3)

- B8 – Cost emerged as a theme in five of the studies, always as a barrier to reducing accidents to children in the home, or to obtaining help if a child had been injured (two [-], two [+] and one [++] ). Three studies found that the perceived cost of installing safety devices or making repairs was a major barrier in the correct use of smoke alarms and in general for safety equipment. However, in one study the provision of free safety equipment, in this case a smoke alarm, led to the equipment being rejected due to suspicions precisely because it was free, which suggests that making equipment or installations totally free may not always be appropriate. (See Recommendations 2 and 3)

- B9 – Four studies (one [-], two [+] and one [++] ) found that young or poorly educated mothers found it hard to anticipate the child’s rate of development in terms of ability to climb, open containers or locks, or light fires. One study, in contrast, found that mothers were good at anticipating developmental milestones and adjusting the home environment in advance of changes, thereby reducing the rate of unintentional injuries in the home (+). (See Recommendations 2, 3 and 5)

(contd over)
- **B10** – One study (++) found that exposure to a child poisoning incident, either in real life or in the media, increased awareness of that particular danger and was a motivator for implementing safety measures. This suggests that providing information on unintentional poisoning via media outlets might be an effective facilitator in raising awareness of risk. (See Recommendation 3)

- **B11** – One study (-) found that adolescent mothers found it hard to deal with issues of blame, oscillating between ideas of the accident-prone child who would have accidents whatever you did, and the negligent adult who was responsible for their child’s accidents. The study recommends that care providers approach the topic of injury in a forthright manner when working with adolescent mothers, challenging the idea that injuries are unavoidable while not assigning blame to the mother for injury to the child. It also suggests that ‘helping mothers identify risks to their specific child in their specific environment may be the most effective intervention’. (See Recommendations 2 and 3)

- **B12** – Five studies (two [-], two [+] and one [++] ) noted the large and constant amount of effort which mothers put into preventing unintentional injuries in the home as a major facilitator of reducing unintentional injuries in the home. Authors picked up on several main components of this maternal safeguarding work – commonsense safeguarding, constant vigilance and teaching children about safety. While these maternal safeguarding activities do act as a short-term facilitator to accident reduction, it is important to note that they are time and energy-intensive and that, for this reason, need supplementing with other forms of unintentional injury prevention. (See Recommendations 2 and 3)

- **B13** – Three studies (two [+] and one [++]) noted cultural practices which, while they may have been adequate safety measures in the parents’ culture of origin, were risky in a new cultural context. There were two aspects to this theme; lack of experience of the particular risks of a host context, and lack of understanding by health officials about different child safety norms and expectations in immigrants’ cultures. Mexican mothers in one US study mostly came from rural and semi-rural backgrounds, so had less experience with urban hazards such as multi-storey buildings and hot water taps which could cause falls or scalds. Mexican mothers were also more likely to use Mexican products, which were more likely to come without safety warnings/packaging. Two US studies found significant cultural differences in experience and expectations which led to health visitors classing behaviour as risky because of a lack of understanding of immigrants’ perception of safety and risk. (See Recommendations 2 and 3)

- **B14** – Five studies (two [-], two [+] and one [++] ) found that a major barrier to child safety in the home was mothers’ worry that asking about child injury in any context, including unintentional injury prevention, or taking an unintentionally hurt child to hospital, would result in the child being removed/seen as at risk, and they would be accused of abuse or neglect. All of these studies were in the US or Canada and focused on low-income mothers, and additionally, most were adolescent mothers or immigrant mothers. (See Recommendations 2 and 3)

- **B15** – Two studies (one [+], one [++] ) found that a major barrier to child safety in the home was mothers’ lack of autonomy to make household or financial decisions. Policies/interventions might need to reconsider the often automatic targeting of mothers about safety equipment or behaviour, especially in populations where the fathers (or parents-in-law) traditionally make decisions about household purchases. (See Recommendations 2 and 3)
Cost-effectiveness evidence

To supplement the cost-effectiveness review, two cost–utility analyses were carried out using the same model of the lifetime costs and effectiveness of relevant home safety interventions.

The first analysis compared the supply and installation of free smoke alarms versus no intervention. It found that a free smoke alarm scheme would probably be cost effective (incremental cost-effectiveness ratio [ICER] £23,046). However, there were many uncertainties in this model and it should be noted that the empirical evidence is inconsistent.

The second analysis compared general home safety consultation and equipment provision versus no intervention. (This includes home safety consultation visits, provision of educational materials and advice, as well as the free supply and installation of a range of equipment.)

The sensitivity analyses demonstrate that, from a public sector perspective, cost–utility is likely to be highly dependent on:

- the proportion of households that participate, the prevalence of existing safety devices in use and the proportion of households that correctly install or use any devices provided
- how long the device is effective (‘functional decay’) and whether or not other changes take place in the household which affect its use
- fixed or overhead costs of programmes relative to the number of households targeted
- number of people in a household and their age
- relative reduction in risk due to the device being properly fitted and used (or due to people adopting safer behaviour in the home).
Relevant Scottish links


2. **A New Look at HALL 4 – the Early Years – Good health for Every Child** (Scottish Government, 2011) [www.scotland.gov.uk/Publications/2011/01/11133654/0](www.scotland.gov.uk/Publications/2011/01/11133654/0)


Important notes for users

1. NICE uses highly developed and rigorous processes to develop its public health guidance, drawing on reviewed evidence on the effectiveness and cost-effectiveness of programmes or interventions, and taking account of stakeholders’ views and fieldwork.

2. Given the above, the recommendations and evidence set out in this briefing have been taken directly from the specific NICE guidance concerned, without critical scrutiny or amendment. NHS Health Scotland cannot be held responsible for these recommendations and that evidence.

3. Aspects of recommendations in NICE public health guidance may require adaptation or amendment for application in the Scottish context. Account may need to be taken, for example, of: Scottish policy and legislative drivers, organisational arrangements, and roles and responsibilities; the existence and applicability in Scotland of national guidance such as SIGN guidelines; the fact that other NICE guidance, where cited, has no formal status in Scotland; and the potential for other resources or services referred to in NICE guidance not to be relevant to Scotland or to have Scottish equivalents.

4. Where NICE guidance other than public health guidance 30 is cited in this Scottish Briefing, users are encouraged to access the corresponding NHS Health Scotland Commentary or Scottish Briefing where available (at [www.healthscotland.com/scotlands-health/evidence/NICE.aspx](www.healthscotland.com/scotlands-health/evidence/NICE.aspx)).

5. NICE points out that implementation of the guidance is the responsibility of local commissioners and/or providers; reminds commissioners and providers 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; and emphasises that nothing in the guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

(contd over)
Users of this Scottish Briefing should ensure that they are aware of, and comply with, their duties under current equalities legislation when assessing the implications of the cited recommendations and evidence for policy, planning and practice in Scotland.

6. In general terms, there tend to be significant gaps in evidence on the effectiveness of particular health improvement interventions among particular equality and diversity groups. When acting on Scottish Briefings on NICE public health guidance, it is important to take account of any such evidence gaps and to consider carefully how to:
   - maximise the potential to reduce health inequalities relating to age, disability, gender (including transgender), language, marital status, race/ethnicity, religion or belief, sexual orientation, or social origin/socioeconomic factors
   - minimise the risk of widening such inequalities.

   Targeting and tailoring of interventions, and delivering them such that their scale and intensity are proportionate to the level of disadvantage experienced by different population groups, have important parts to play in these regards.

7. NICE public health guidance provides important information on contextual and other considerations taken into account in developing the guidance and its recommendations. It also explains the processes involved, identifies gaps in the evidence, and makes recommendations for research to fill these gaps.

8. NICE public health guidance 30, the review reports that informed it, and other related material and information can be found at www.nice.org.uk/ph30

9. For further information on this Scottish Briefing, or to provide feedback, please contact Dr Eileen Scott, Public Health Adviser (Evidence for Action), NHS Health Scotland – eileen.scott1@nhs.net

All available Scottish Briefings on NICE public health guidance (and the earlier NHS Health Scotland Commentaries and Scottish Perspectives) can be found at www.healthscotland.com/scotlands-health/evidence/NICE.aspx

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