Public Health Intervention Guidance

Health Inequalities Draft Scope Consultation – Stakeholder Response Table

29 January to 26 February 2007

Section	Stakeholder Organisation	Evidence submitted	Comments Please insert each new comment in a new row.	Response Please respond to each comment
1	*Heart of Birmingham PCT*		Not clear what definition used for " proactive case finding " and how this differs from the systematic use of GP population and disease registers /IT systems e.g. to case find and manage individuals in at risk categories This approach is almost certainly the most systematic and effective in terms of overall population impact compared with ad hoc initiatives suggested e.g. health trainers which seldom reach more than 10% of the population and have no evidence base Need to be clear that only 60% of individuals at high risk of premature death will be found in areas classified as being disadvantaged (see Acheson report) therefore need to be able to generalise findings to all at risk individuals – not focus on area based approaches to case finding . the need for guidance [Section 3 indicates the problem of adopting an area based approach once you get below LA level . The term " retention " is used but not really defined or described in tems of subsequent scoping statement – does this mean risk management and compliance ? Need to acknowledge that part of life expectancy HI is due to infant mortality and specifically exclude this in terms of scope	Thank you for your comments. The guidance will draw on evidence from published and grey literature on a broad range of activities around pro-active case finding and retention, in particular around smoking cessation services and prescription of statins. We envisage that this will include use of GP registers, interventions around compliance and risk management, and a range of other approaches – what is included will be determined by the evidence that is available. More detail will be provided in the full reviews. NICE recognise the importance of reducing infant mortality in tackling health inequalities, and although it has been excluded from this draft scope, NICE will be recommending the development of future guidance in this area.

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1	*LB Newham*		We suggest that the guidance title is amended to "Guidance for the NHS and Local Strategic Partnerships on interventions …" It is our view that by simply directing the guidance at the NHS, its potential audience will be narrowed. Whilst the NHS clearly has the lead in terms of primary prevention for CVD and cancer, even in terms of the scope of this guidance, local authorities and voluntary and community sector partners (including Registered Social Landlords and community enterprises), may be core to supporting communities and individuals to access services. When it comes to secondary prevention, the bulk of resources (both financial and human) may well sit with local authorities and other LSP partner agencies rather than the NHS. For example, LB Newham spends around £5 million of mainstream funding on commissioning and directly providing sports, leisure and physical activity services, compared to around £115,000 from the PCT on exercise on referral schemes. Increasingly funding, including mainstream NHS and local authority funding is pooled under Local Area Agreement (LAAs). In fact for "spearhead" local authority areas, the PSA targets on life expectancy and CVD are mandatory targets with their LAAs.	Thank you for your comment. NICE recognise that there are a number of different organisations whose work will impact on inequalities, alone or in partnership with others. The referral handed to NICE from the Department of Health specifically requests that guidance be developed for the NHS in this area. Where appropriate this guidance will extend to organisations working outside of or in partnership with the NHS, whose work impacts on health inequalities.
1	*Royal College of General Practitioners (RCGP)*		Need to be clear what we mean by proactive case finding – is it for example screening? Also what does retention relate to – retention of individuals within the system	The guidance will draw on evidence from published and grey literature on a broad range of activities around pro-active case finding and retention, in particular around smoking cessation services and prescription of statins. We envisage that this will include use of GP registers, interventions around compliance and risk management, and a range of other approaches – what is included will be determined by the evidence that is available. More detail will be provided in the full reviews.

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1	*NHS Health Scotland*		See relevant 'General 1, 'General 2' and 'General 3' comments. Further to 'General 3' comment, it would be helpful to look for evidence relating to people who are disadvantaged in any of a range of ways, whether or not they live in disadvantaged areas. In addition, given that the review work is not expected to cover disease/mortality outcomes, it would seem appropriate to replace 'interventions that reduce the rates' with 'interventions designed to reduce the rates'.	Thank you for your comment. The guidance will consider, where possible, disadvantaged adults as well as adults in disadvantaged areas. The scope will be amended to reflect this. NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities.
1 (and 4.3.1, 4.6)	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the following:* *- Department of Communities and Local Government (DCLG)* *- Department for Education and Skills(DFeS)* *- Her Majesty's Treasury (HMT)* *- DH Obesity Team* *- DH SATs* *- DH CMHU* *- Department for Culture Media and Sport (CultureDCMS)*		The original referral from the DH called for "..the NHS *and other sectors"*. We feel that it is important that the potential role of other sectors such as other Government Departments, Local Authority (LA), should be considered and that this forms an integral part of the scope and guidance. Would you please clarify what you mean by an "NHS intervention". We feel that in light of Local Area Agreements, Partnership work, joint commissioning and a move to a plurality of suppliers of health and health care services that a focus on "NHS interventions" may not be practical and would certainly be limiting in application. We feel that it is essential that this scope is not limited to either NHS or medical interventions and should be inclusive of all potential interventions that encourage pro-active case finding, retention and access.	Thank you, noted. The wording in the scope will be amended accordingly. Although the areas identified in the scope are limited to the use of statins within the NHS and NHS interventions to help people stop smoking, NICE recognise that there are a number of different organisations whose work will impact on inequalities, alone or in partnership with others. Where appropriate, this guidance will extend to organisations working outside of – or in partnership with the NHS, if their work impacts on health inequalities. Agreed, the focus of this scope is proactive case finding, retention and access to services. In this context the outcome measures are concerned with service provision rather than the effectiveness of interventions.

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1.1	*British Psychological Society*		Important content is lost in the transition from guidance title to short title. Social level intervention especially *prevention* is vital is we are to address the problem of reduction in new cases – 'proactive case finding' only kicks in when someone is a case, *primary prevention* is far more effective. Reference to 'disadvantaged areas' is omitted in the short title: but it is vital to remember that illness is socially structured (and this is reflected in geographical distribution).	Thank you for your comment. NICE recognises the importance of primary prevention, and this is covered across a range of other topics in NICE guidance (both completed and in development), which may be viewed here: **http://guidance.nice.org.uk/type** This intervention guidance is specifically about the role of approaches such as proactive case finding, retention and improving service access in tackling health inequalities by improving service use and compliance in vulnerable and excluded groups. It will consider evidence about approaches and interventions in disadvantaged areas, and also where appropriate about disadvantaged adults in general (since a proportion of disadvantaged adults live outside of disadvantaged areas). NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities.
2. a	*Boehringer Ingelheim Ltd*		We recognise the practicality of the approach of focusing on those local authorities in the bottom fifth and those now covered by the 'spearhead group' of 70 local authorities and 88 primary care trusts (PCTs). We hope that the resultant guidance will recognise that the index of multiple deprivation often fails to identify pockets of deprivation particularly in rural communities and those embedded within affluent areas. We would like to see the principles and approach developed by NICE to be cognizant of this bias and ensure that any recommendations support the challenges, particularly around access, that are found in rural and affluent areas.	Thank you for your comment. NICE recognise that this guidance should span both disadvantaged areas, and disadvantaged adults (who will not necessarily live in deprived or disadvantaged areas). The scope will be amended to reflect this.

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2. a	*British Psychological Society*		There is specific reference to cancer and cardiovascular disease but actually according to epidemiological research the social class gradient in mortality is found in almost all major causes of death (apart from skin and breast cancer). Within cardiovascular disease, heart failure is especially under recognised. Community psychology work on heart failure is being carried out in Edinburgh. Note b suggests that this guidance is expected to update all of the frameworks listed under b. This would appear to be a rather daunting task.	Thank you for your comment. NICE recognise that a social class gradient exist s across a wide range of illnesses. As a consequence of this consultation, and discussions with members of the Public Health Intervention Advisory Committee, to keep the scope manageable it will be narrowed to focus on evidence around smoking cessation services and prescription of statins. You are encouraged to suggest other topics for future NICE guidance **http://www.nice.org.uk/page.aspx?o=ts.home** The guidance will not physically update each framework listed in appendix B, but should be taken to supercede them where appropriate.
2. a	*Brighton & Hove City PCT*		Although the guidance is likely to be used by all PCTs, by focusing on spearhead PCTs there is a possibility that some PCTs will believe that this guidance does not apply to them and hence some of the power of NICE to bring about change for people living in disadvantaged areas will be lost. It is not clear which PCTs/LAs qualify as 'spearhead'. Brighton and Hove City Council receive Neighbourhood Renewal funding which recognised the levels of deprivation in certain areas but we are not aware we are referred to as a 'spearhead' .	Thank you for your comment. We agree that the scope should not be limited to spearhead PCTs and we recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it covers both disadvantaged areas and disadvantaged adults (who will not necessarily live in disadvantaged areas). It will also be amended to include other organisations outside the NHS.

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2. a	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		Following the re-organisation of the NHS, there are now 62 Spearhead PCTs, would you please consider amending.	Noted, thank you.
2. a	*Royal College of Nursing*		a) Whilst we would recognise the importance of targeting interventions to those areas where it is most needed, NICE should also consider that there are 'pockets of deprivation' hidden in many areas which could be regarded as affluent from available statistics. Professionals working in these areas often find it challenging to secure funding to support the development of resources for changing individual's behaviour to one that is health promoting and illness reducing.	Thank you for your comment. NICE recognise that this guidance should span both disadvantaged areas, and disadvantaged adults (who will not necessarily live in deprived or disadvantaged areas). The scope will be amended to reflect this.
2. a	*Sheffield PCT*		Is it possible not to use spearhead areas as a focus as this government targeting policy may change (as it has done previously)? If it has to have a geographical element, can it not be determined at a lower level than local authority? Perhaps super output area?	See previous response: We agree that a focus on deprived areas alone is limiting, and will amend the scope.

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<table>
<tr>
<td>2. b</td>
<td>Boehringer Ingelheim Ltd</td>
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We note that current NSF and best practice guidance for stroke is not referenced within the scope, in particular:

o Chapter 5 Older Persons NSF which addresses service issues for stroke management (1999)
o Improving stroke services: a guide for commissioners (2006)
o Action on Stroke services a toolkit for commissioners (ASSET2)
o Older People’s National Workforce Competence Framework (2004)

When taking into consideration the preventative aspects of NSFs we believe there is an opportunity to link this guidance to the development of the NSF for renal disease part 2 which looks at chronic kidney disease.

▪ We recognise the challenges of the current focus of the guidance in restricting the guidance to cardiovascular disease and cancer but would suggest that this is an opportunity for the guidance to work with and inform the current COPD NSF. Respiratory disease (including lung cancer) is the second most common cause of mortality for both men and women and the mortality rate is falling more slowly for respiratory disease than for other major diseases (see figure below % decrease in mortality since 1993 by disease area - Department of Health (unpublished))

<table>
<tr><th>Group</th><th>Males</th><th>Females</th></tr>
<tr><td>Respiratory disease</td><td>23</td><td>6</td></tr>
<tr><td>CHD</td><td>40</td><td>41</td></tr>
<tr><td>Cancers</td><td>18</td><td>24</td></tr>
<tr><td>Diabetes</td><td>28</td><td>30</td></tr>
</table>

• Furthermore there is a clear link between COPD and socio economic deprivation: Men aged 20-64 employed in unskilled, manual occupations in England and Wales are around 14 times more likely to die from chronic obstructive pulmonary disease than men employed in professional roles and around 7 times more likely than those in managerial and technical occupations

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<td>
Thank you for your comments and additional references. As a result of this consultation, and discussion amongst the Public Health Interventions Advisory Committee, the scope will be narrowed to focus on smoking cessation services and prescription of statins, in the first instance. This will ensure that we are able to examine key aspects of the topic in sufficient depth.
You are encouraged to suggest other topics for future NICE guidance http://www.nice.org.uk/page.aspx?o=ts.home
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2. b	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		We feel that the applicability and relevance of this guidance will extend beyond "professionals with public health as part of their remit working within the NHS" and will include commissioners in Local Authorities, Other Government Departments as well as the voluntary and third sector. Would you consider taking a more inclusive approach to the applicability of the guidance.	Thank you, noted. As indicated above, where appropriate this guidance will extend to organisations working outside of or in partnership with the NHS, if their work impacts on health inequalities.
2. b	*Department of Health* **** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS***		Would you please consider, amending the government policy documents to include: • "Health Challenge England- next steps for choosing health" http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/ChoosingHealth/fs/en • the NHS operating framework http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127117&chk=BgslVK • the Older people's NSF (Stroke Services) http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4002292&chk=Z9zK4j • work is currently ongoing on developing a National Stroke Strategy http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Stroke/StrokeArticle/fs/en?CONTENT_ID=4132138&chk=GkfUIj	These documents have been added to the scope.
2. b	*LB Newham*		The guidance should be aimed wider than "professionals with public health as part of their remit working within the NHS" and should include working within the NHS and Local Strategic Partnership agencies for the reasons stated above.	Thank you for your comment. We appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS.

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2. b	*Royal College of Nursing*		B last bullet point - By aiming this guidance development at 'health professionals with public health as part of their remit working within the NHS' will potentially restrict its applicability. If all health professionals and practitioners embrace health promotion as a key element of their role by using every contact with the public as an opportunity to explore health rather than focus on illness, there is likely to be a greater chance of success.	Thank you for your comment. We recognise and appreciate that there are a number of different organisations that have an impact on inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS.
2. b	*Royal College of General Practitioners (RCGP)*		It is implied that this guidance will update an NSF – is this correct as it means a lot of work and areas that are not covered by specific NSFs	The guidance will not physically update each framework listed in appendix B, but should be taken to supercede them where appropriate.
3	*Boehringer Ingelhim Ltd*		The need for guidance: ▪ In section 3 the focus of the draft is the mortality rates associated with different diseases in deprived populations. We believe consideration of the morbidity associated with chronic disease, especially cardiovascular disease, should also be highlighted. This is especially important given the falling mortality rates for diseases such as CHD and stroke which don't reflect the incidence and lifetime burden/disability of these diseases. ▪ In our experience of working with healthcare professionals and local PCTs a key concern to access the hard to reach groups such as black and minority ethnic (BME) is literacy. This presents a significant barrier in health education and promotion. Again we would reiterate the need to recognise hidden deprivation in affluent and rural areas.	Thank you for your comments. NICE recognise that morbidity rates for many chronic diseases, especially cardiovascular disease, show a socio-economic gradient. As a result of this consultation and discussion by the Public Health Intervention Committee, this guidance will focus on pro-active case finding, retention and access to services for smoking cessation and prescription of statins. Key interventions for meeting the PSA target on life expectancy, these interventions also encompass a number of chronic diseases. Interventions aimed at overcoming problems with literacy will be included under 'improving access to services'. This guidance will consider both disadvantaged areas, and disadvantaged adults (who will not necessarily live in deprived or disadvantaged areas). The scope will be amended to reflect this.

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3	*Southwark PCT*		*Whilst 3d highlights the link between deprivation and health of people with mental illness and learning disabilities, there is a need to offer guidance because of worsening public mental health in general. With depression a leading cause of DALYs and the co-morbidity of mental illness and physical illness regardless of income (tho'exacerbated by low income), there is surely a need to identify the issues around mental illness and the impact on life expectancy. Suicide figures are only a part of this.*	Thank you for your comments. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
3. a	*British Psychological Society*		The impact of societal inequality on population health, as opposed to health inequalities within societies, is under-recognised and under-addressed. Societies with greater inequality in distribution of wealth are less healthy than societies with more equal distribution of wealth even if the former are richer in terms of GDP. Psychosocial processes almost certainly mediate this (see RG Wilkinson's work). The need for guidance is well presented.	Unfortunately this falls outside the remit of the scope. NICE will recommend that future guidance be developed on population based approaches to reducing health inequalities. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
3. a	*Department of Health* **** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS***		Would you consider amending the first sentence, the word "many" should be inserted before "inequalities in health are increasing" to better reflect the point that not all health inequalities are increasing. In 1972-76, men in social class I lived an average of 5.**4** years longer than those in **social class V.** In **1997-2001,** this disparity had grown to **8.4** years (reference from the Status Report of 2006). Would you consider updating this section?	Thank you for this suggestion. This section has been amended. The word 'many' has been added to revised section 3c. The data relating specifically to social class no longer appears in this section.
3. c	*Department of Health* * The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCM*S*		Would you please delete "and Wales" as the Spearhead group is confined to England.	Thank you, noted. The scope has been amended and no longer refers to spearhead PCTs.
3. d	*Stoke on Trent PCT*		Section 3(d) – The need for guidance page 3 It cites people with learning disabilities or mental health are particularly at risk of poor health. I think this should read 'people with learning disabilities and people with mental health are particularly at risk of poor health.'	With a further narrowing of the scope this section will be deleted.

3. d/e	*LB Newham*		Maybe merits additional references to work of Wilkinson and others on psycho-social dimensions of health inequalities	Noted, thank you.
3. f	*Boehringer Ingelhim Ltd*		The government performance management framework for primary care (Quality and Outcomes Framework) does not adequately identify and systematically manage the disadvantaged. We hope that this guidance will support the development of an outcomes orientated approach to supporting the disadvantaged groups at risk of premature death through better medicines management, diagnosis and treatment.	Noted, thank you.
3. f	*Department of Health* * The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCM*S*		This section appears to contain the wrong life expectancy PSA formulation, the formulation used is the 2002 version (incorrectly labelled as 2004),"to reduce the gap in life expectancy between the fifth of areas with the **lowest life expectancy** and England". Please would you clarify and consider amending to read as follows: "reduce by at least 10% the relative gap (i.e. percentage difference) in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and England as a whole."	Thank you, noted. We have replaced the 2002 version with the version you recommended in your latest correspondence with NICE.
3. f	*National Childbirth Trust*		Including child and perinatal mortality within the scope of the guidelines would contribute to achievement of the government public service agreement (PSA) targets set in 2004.	NICE recognises the importance of achieving the PSA target on infant mortality. However, it falls outside of the remit of this guidance. NICE will be recommending the development of future guidance to help reduce infant mortality. We also encourage you to suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

3. f (also 4.1 and 4.3)	*Sheffield PCT*		The scoping document is focusing on premature death. As I commented at the stakeholder event I believe this would be better served if the target populations were less defined by high level geographical localities but at their risk of premature death regardless of where they live, their ethnicity or educational achievement. I believe therefore that the focus should be around interventions that will contribute to shifting the distribution around the mean and in order to do that the focus could be on premature deaths under 65. This age is used by the EU and WHO as approximately 20% of deaths occur before this age. This by its nature will focus efforts where premature deaths from the major killers (CVD and Cancer) occur and not miss the significant number of people outside spearhead PCTs/local authorities. It also may reach those disadvantaged communities within more affluent areas. The lists of population groups and geographical areas you cite may guide people to where the greatest numbers of premature may concentrate but does not exclude any PCT from eventual contribution to reducing inequalities. The scoping should be developed irrespective of the current target of reducing the gap by 10% that almost requires non-spearheads to do nothing more to improve health. Again the target may be subject to change but this should not affect the guidance on approaches to reducing premature death. It may also be worth noting that any success in reducing mortality under 65 may lead to deteriorating figures in morbidity in the over 65s as more people survive but in poorer health.	As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, this scope will be narrowed and the guidance will consider the effectiveness of interventions on proactive case finding, retention and improving access to services, specifically with regard to smoking cessation services and the prescription of statins. It will also consider, where possible, disadvantaged adults (wherever they live) and those in disadvantaged or deprived areas. NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities. We have used the Office for National Statistics definition of premature deaths which are deaths that occur before the age of 75 years.

3. f	*Southwark PCT*		Exploration of the connection between PSA targets and QoF would be useful as they are unlikely to be reached unless there is adequate leverage in the Quality and Outcome Framework. E.g. Any guidance aimed at increasing proactive case-finding needs to ensure that it is integrated with the GP contract and adequately incentivised. If health inequalities are to be treated as mainstream, rather than as optional bolt ons to mainstream policy, procedures for mitigating them need to be fully incorporated into the QoF framework. This would have the advantage of providing regular and comparable data nation wide. At the moment this integration is weak in some areas. The QoF targets do not seem to be as fully integrated with the need to tackle health inequalities. More use can be made of disease registers – at the moment there is insufficient incentive for doctors to increase their size. CVD Risk registers are not currently part of QoF, an indeed comorbities are not well dealt with. Ethnicity monitoring is rewarded by 1 QOF point for 100% of new patients – scarcely worth striving for! If we are really to get a handle on the ethnic component of health inequalities, collection of ethnic data needs to be routine in practices and reported within the QoF framework. In terms of records, the QoF maximum payment is available when 80% of patients of 45 years or over have had their bp checked in the last five years. Should this not be made a more stringent requirement?	Thank you for your comments, which we have noted. NICE recognise that the guidance will need to be developed in the context of health systems and structures like the QOF. As well as considering any available evidence on the impact of service structures on interventions, there will be an opportunity to explore these issues when the draft guidance goes out for consultation and fieldwork.
4.1	*Sandwell PCT*		With reference to section 4.1 groups covered. There is no mention of young people in the classifications, considering young people class themselves as from 12 to 25 years.	.As a result of this consultation, and discussions within the Public Health Advisory Committee, this scope will be narrowed to focus on proactive case finding, retention and access to services with reference to smoking cessation services and prescription of statins. Interventions that include users/or potential users, of either service or treatment will be covered. Users of the smoking cessation services are generally aged 16 years and older. In the case of statins, NICE guidance relates only to adults and the use of statins within their licensed indications.

4.1.	*Southwark PCT*		Targeting high risk groups will undoubtedly have benefits, however, many disadvantaged populations also have large numbers of people who may be at high risk of dying prematurely due to heart disease, stroke and cancer in the future. As many determinants of such illnesses are set early in life, additional recommendations on identifying and providing services for future high-risk individuals would be beneficial. Should there be similar guidance issued with respect to children?	Thank you. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home NICE will also recommend that future guidance be developed to help reduce infant mortality.
4.1.1	*Birmingham Strategic Partnership*		We believe it would be helpful to look at illiteracy as a separate issue, distinct from low educational achievement	Thank you for your comment. This guidance will consider interventions to improve access to services, in which we include approaches that focus on literacy issues.
4.1.1	*Birmingham Strategic Partnership*		We would like NICE to consider young people (under 21 years) who do not have permanent accommodation	Thank you for your comment. Unfortunately a specific focus on this group falls outside the remit of the scope. However, should information on these groups be reported in the context of evidence on proactive case finding, retention and access to services with respect to smoking cessation and/or statins such information will be considered. In the meantime you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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4.1.1	*Blackpool PCT*		Guidance is required on those causes of death that impact significantly on the spearhead area's i.e. o Accidents o Suicide/Mental Health o Drug Overdose o Alcohol related disease The evidence of interventions to these should also be considered. Other groups in greatest need include: o Young people not in education employment or training Adults with a physical disability	Thank you for your comments. Unfortunately your suggestions fall outside of the remit of this particular guidance, however we encourage you to suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home..
4.1.1	*Boehringer Ingelhim Ltd*		▪ As stated above we believe there is an opportunity to include respiratory disease and link this guidance to the development of the COPD NSF. ▪ It is unclear from the scoping document if asylum seekers and refugees will be included in the BME. This group have unique needs particularly around access to services and continuity of care ▪ It is hoped that rurality will be covered as part of the criteria for adults who have difficulty in accessing services ▪ Literacy is not covered within the target population and yet is a significant factor in adults accessing services and maintaining good health	Please see our previous response. Since the scope will now be narrowed to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins, we will consider appropriate evidence in any of these areas, with vulnerable or disadvantaged groups. Literacy will be considered under access to services.
4.1.1	*British Psychological Society*		Disabled people more generally need to be included.	Thank you for your comment. As a result of this consultatio , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. Disabled people using these services / treatments are included in this remit.

4.1.1	*British Psychological Society*		There seems to be some confusion between the risk associated with being in a socially excluded/deprived group and being 'at higher-than-average risk of CVD'. Is group membership per-se assumed to index risk, or is it the usual risk factors (smoking, hypertension, etc) in this group? Looking ahead to 4.3.1 suggests that the guidance will involve first identifying the community and then doing case-finding, etc.	Thank you for your comment. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. The groups listed are examples of what those 'adults' could be, rather than an exhaustive list.

4.1.1	*College of Occupational Therapists*		People with a learning disability need equal access to primary care teams and it has been suggested that this is due to a lack of knowledge and skills in these teams rather than any wish on the part of the individuals to access services. (DRC, 2006)	Thank you for your comment. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. This will include people with a learning diability, where evidence is available. It would be helpful if you could submit or direct NICE towards your sources of this information.
4.1.1	*Department of Health* * The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCM*S*		Currently only the following; Heart disease, stroke and cancer are within the scope, would you consider changing these to reflect the three leading causes of premature death in disadvantaged areas that are cardio-vascular disease, cancer and respiratory disease. This will enable case finding for diabetes, COPD as well as heart disease, stroke and cancer to be considered.	As the focus of the scope is on the use of statins for CVD and smoking cessation – these treatments will include the leading causes of premature death you have mentioned.

4.1.1	*Department of Health* * The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCM*S*		We feel that this needs to be closely defined both in terms of the baseline of the average, over what time line etc In our opinion it would be of benefit to consider defining the scope in relation to adults who: are part of definable groups with known elevated risk e.g. certain BME communities have elevated rates of diabetes; smokers have significantly elevated rates of respiratory disease, CVD and cancer and people who live in "multiple disadvantaged areas". The definition of elevated risk may be from epidemiological research, existing service utilisation data or local death rates and we would be happy to discuss/ expand on this as appropriate.	The life expectancy PSA target specifies a timeline of 2010. This timeframe has been added to the relevant section of the scope. Thank you, noted. The revised scope focuses on smokers and/or people with, or at risk of developing, CVD.
4.1.1	*East of England Public Health Group*		The groups that will be covered as set out in the draft scope paper appear to be very loosely defined, with no definition of their key features such as poverty, social exclusion, vulnerability.	Thank you for your comment. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. The strategies for searching for evidence on different population groups will include specific and generic terms.

4.1.1	*East of England Public Health Group*		Appears to ignore children and young people and the importance of suicide, drugs, alcohol and accidents in disadvantaged young men. We understand the need to target adults in the first instance; however we have a concern that excluding children and young people as part of this population does not address likely future health inequalities.	Thank you for your comment. NICE recognises the importance of the issues you raise. Unfortunately this would constitute a substantial programme of work which exceeds the remit of intervention guidance. As such, they fall outside the remit of this scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.1.1	*East of England Public Health Group*		Likewise, ignores gypsies and travellers as an ethnic group	Thank you for your comments. Please see our earlier response: The scope will be amended and will consider evidence on the key approaches used in smoking cessation services and prescription / use of statins, for all adult groups, where evidence is available.
4.1.1	*East of England Public Health Group*		NICE need to be aware that targeting resources to high risk groups may disadvantage the rest of the population. If no additional resource is allocated to the NHS, this has to be acknowledged as a risk. However, our collective view in the Public Health Group is that we support initiatives aimed at reducing health inequality gap.	Thank you for your comment, which we have noted. The economic work will consider opportunity costs. NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities.
4.1.1	*East of England Public Health Group*		By taking an approach based on targeting individuals and/or groups, there is a risk of reducing the effect of the intervention compared to an approach which targets specific geographical areas. This is because the causes of disadvantage are likely to be social, economic and environmental, and therefore found within particular geographical areas.	Thank you for your comments. NICE recognises the importance of the wider determinants of inequalities in health and will recommend that future programme guidance be developed for tackling these.
4.1.1	*East of England Public Health Group*		An approach which seeks to identify individuals runs the risk of stigmatising people	Agreed. Thank you for your comment.

4.1.1	*Heart of Birmingham PCT*		Suggests adults from some black and minority ethnic groups – need to define which ethnic group – who will and will not be excluded.	Thank you for your comment. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.

4.1.1	*National Childbirth Trust*		Whilst it is recognised that to have a short-term impact on mortality in adults, adults must be targeted, the overall aim is to reduce premature death. Many babies and children are at increased risk of death because they are born prematurely or small for gestational age. Some of those that survive infancy have a shorter life expectancy.	Thank you for your comment. Unfortunately this falls outside the remit of this scope. NICE are currently developing guidance on maternal and child nutrition (http://guidance.nice.org.uk/page.aspx?o=MaternalandChildNutritionMain) and smoking cessation with particular reference to pregnant smokers (http://guidance.nice.org.uk/page.aspx?o=SmokingCessationPGMain) which will address some of the issues around low birthweight and infant health. In addition, NICE will be recommending the development of future guidance on infant mortality. We also encourage you to suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.1.1	*NHS Health Scotland*		It would be helpful to look for evidence of relevance to all of the diversity strands (see 'General 3' comment), and to expand on the last bullet point – 'adults who have difficulty accessing services' – to specify possible reasons for such difficulty. See also 'General 3' comment.	Thank you for your comment, it is noted and agreed.

4.1.1	*Royal College of General Practitioners (RCGP)*		Need to establish age group as targets in 2a) refer to under 75's and this guidance is for adults – what about over 75's; children given life expectancy at birth is given? Also we know that life course has a profound effect on chronic diseases such as CVD	Thank you for your comment. Unfortunately, over 75's and children are outside of the remit of this particular guidance. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. We encourage you to suggest another topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.1.1	*Royal College of General Practitioners (RCGP)*		Adults from *some* Black and minority ethnic groups – need to define and state these. Also will be difficult as all sections of the BME communities reside in deprived areas/spearhead pcts	Thank you for your comment: Please see our previous response. We will consider appropriate evidence on all adult users of these services / treatments.

4.1.1	*Royal College of Nursing*		It is not clear why children have been excluded from this document. Infant mortality in certain BME groups is significantly higher than the general population – if this group is not covered by the index of multiple deprivation (section 2) it should be explicitly detailed in this section. Further, if infant mortality is to be dealt with separately in another guideline, this should be clearly stated.	Thank you for your comment. NICE recognises the importance of tackling infant mortality. However, it falls outside of the remit of this guidance. NICE will be recommending the development of future guidance in this area. We also encourage you to suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.1.1	*Royal College of Nursing*		Mental health and learning disability should be separate bullet points rather than as presented here.	Thank you for you comment, the scope has been revised.
4.1.1	*Royal College of Nursing*		Suicide attempts mentioned in 3B but does not appear in 4.1.1. Sometimes suicidal ideation and attempts are not the products of psychiatric disorder (e.g. those with long term or terminal illness).	Noted. Thank you for your comment.
4.1.1.	*Southwark PCT*		Ensure that carers, disabled people and those with long term illness and those on incapacity benefit are represented. One issue that will need to be considered is the very poor and patchy data on ethnicity in primary care. Collection of ethnicity is mandatory in secondary care. At present it is hard to clearly track primary and preventative care in ethnic groups because of the lack of clear data. At present too ethnicity data is not collected on death certificates and this makes it hard to be correlate ethnicity and premature death. As BME groups age, these lacunae will become a greater data problem. Unhelpful to lump poor and socially excluded together. There may be a link but the two are not synonymous. *Similarly we consider that mental health problems and learning disabilities should be treated separately as the issues are very different*. Unemployed is a vague term. Greater specification needed. E.g. people of working age who are not employed.	Thank you for your comments. We recognise the distinct differences between identified groups and distinct terms, as well as more generic terms, will be used in the searches for evidence. Gaps in the evidence base will be noted and reported in the final guidance document.

4.1.1.	*Stoke on Trent PCT*		Section 4.1.1. Populations – Groups that will be covered. Page 5 Bullet point 1 and 7 – perhaps a bit more clarity as to the distinction between adults who are poor/ and or socially excluded and adults who have difficulty accessing services – e.g. provide example for each that is different from the other specific groups of people listed.	Thank you for your comment. We agree it is important to distinguish between issues relating to access– which may differ between different population groups- and issues relating to adults who are poor or socially excluded.
4.1.1.	*Stoke on Trent PCT*		Section 4.1.1. Populations – Groups that will be covered. Page 5 5th bullet point – again the paper cite adults with mental health or a learning disability. See above comment – as it infers an either or – when in reality both groups are also high risk to pre-mature death.	Comment noted and agreed – the scope will be amended accordingly. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.

4.1.1	*Surrey PCT*		I'm concerned that the focus is only on disadvantaged areas, although you then refer to groups	As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities.
4.1.1	*Surrey PCT*		I think Travellers should be specifically mentioned as a target group, even though they are socially excluded and a BME group. They experience the poorest health…but may not be easy to identify as/in a disadvantaged area	Thank you for your comment: Please see our previous response.
4.1.1	*UK Public Health Association*		The common factor in this list of target groups is low self-esteem, lack of autonomy and control. This results in high levels of stress, anxiety and depression which give rise to excess mortality levels. Positive approaches to improve wellbeing are more likely to be successful than approaches that target individual risk factors which can result in victim blaming with further undermining of self-esteem.	Thank you for your comments, which we have noted. You may also be interested in the developing NICE guidance on behaviour change (http://guidance.nice.org.uk/page.aspx?o=BehaviourChangeMain) Which addresses some of the issues you raise.

4.3	*Blackpool PCT*		Interventions to improve Mental Health reduce accidents, reduce CVD deaths due to cold	Thank you for your comments. Unfortunately a specific focus on mental health falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home However, as a result of this consultation and discussions with the Public Health Intervention Advisory Committee the scope now includes prescription/use of statins to prevent or manage CVD.
4.3	*British Heart Foundation*		The narrow focus of the guidance is made even more narrow in specifying that the guidance will only look at targeted NHS interventions aimed at supporting adults living in disadvantaged areas or aimed at improving services for adults with a higher risk of premature death from heart disease, stroke and cancer. The current wording may stop people from submitting evidence on NHS interventions that are applied universally i.e. not targeted, that have a disproportionate benefit to people in high risk groups. These interventions are not necessarily macro level policies that address the wider determinants. We would suggest a third area under 4.3.1 along the lines of "NHS interventions that are universally available but show evidence of having a disproportionate benefit for adults who live in disadvantaged areas who have a higher than average risk of premature death from heart disease, stroke and cancer."	Thank you for your comments. We recognise that organisations and practice across a range of sectors, working alone or in partnership with the NHS, will have an impact on health and the scope will reflect this. As a result of this consultation the scope now includes vulnerable or disadvantaged adults (wherever they live) as well as disadvantaged areas. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.3	*NHS Health Scotland*		See 'General 1' and 'General 2' comments. In addition, in seeking to inform the development and delivery of interventions/activities aimed at reducing and/or eliminating premature death from cancer, heart disease and stroke, there may well be lessons (on initial engagement, maintenance of engagement, and promotion of concordance) to be learned from interventions/activities that might contribute to these outcomes but are not explicitly aimed at them or expected in themselves to lead to them – and indeed from interventions/activities unrelated to cancer/heart disease/stroke.	Thank you for your comments. The focus of the scope is service provision including access, recruitment, uptake and retention rather than the effectiveness of the intervention per se. In order to keep the guidance manageable, and enable us to consider the topic in sufficient depth, it has been necessary to place some limitations on the scope. We recognise that there will be learning from other areas to contribute, and you are encouraged to submit any additional evidence when the synopsis of the evidence goes out for consultation. You can also suggest a new topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.3	*South Asian Health Foundation*		Need to define premature death	Thank you for your comment. The definitions outlined in the scope around mortality and adults have been guided by definitions from the Office of National Statistics and the World Health Organisation.
4.3	*South Asian Health Foundation*		Addressing health inequalities needs to accommodate premature morbidities too. E.g. diabetes – premature disease fules inequalities, morbidity and mortality in BMEGs, so will screening for this condition be accommodated in the scope?	Thank you for your comments. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.3	*South Asian Health Foundation*		Will the coordination of primary prevention strategies for CVD be covered?	As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.
4.3	*South Asian Health Foundation*		Ethnic coding is mandatory in secondary care, but only for new registrants in primary care, so will guidance look at ethnic coding – without this, attempts to address inequalities or paint the canvas are very difficult and in some cases, futile.	Thank you for your comment. Where ethnic coding is included in evidence on pro-active case finding, retention and access to services for the areas outlined in the scope it will be considered. Gaps in the evidence base are noted during the collation and synthesis of evidence and reported in the final guidance,
4.3	*South Asian Health Foundation*		Access to existing CVD services should be covered in order to define where the inequalities arise.	Thank you for your comment. The scope has been amended and includes a specific reference to the prescription /use of statins to prevent or manage CVD.

4.3	*South Asian Health Foundation*		I would be delighted to sit on the PDG and feel I have much to offer	This guidance is an intervention and is therefore developed by the Public Health Interventions Advisory Committee (PHIAC) which is a standing committee rather than a programme development group. We would be very grateful for your expertise when the draft guidance goes out for consultation when you will be invited to give feedback and submit any additional evidence. For further details please refer to the NICE public health guidance development process manual: www.nice.org.uk/phprocess

4.3.1	*Birmingham Strategic Partnership*		We would like NICE to consider interventions commissioned by partner organisations: e.g. relief of poverty through benefits advice and debt counselling	Thank you for your comment. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. The guidance will apply to the NHS and, where appropriate, non-NHS organisations. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home NICE will recommend that tackling the broader determinants of health inequalities be considered for the development of future guidance.
4.3.1	*Birmingham Strategic Partnership*		We would like NICE to consider interventions that proactively seek to communicate health issues to people living in deprived communities: social marketing	Thank you for your comment. This is covered by the scope. You may also be interested in the NICE guidance on behaviour change, due for publication in November 2007, which considered some of the issues you raise: http://guidance.nice.org.uk/page.aspx?o=BehaviourChangeMain

4.3.1	*Birmingham Strategic Partnership*		We would like NICE to consider interventions that proactively seek to deliver health improvement services to people living in deprived communities, e.g. use of multi-lingual call centres for improving access and proactive call-outs to recruit clients	Thank you for your comment, proactive case finding is a key consideration in this scope. .
4.3.1	*Birmingham Strategic Partnership*		We would like NICE to consider interventions that offer easy access to deliver health improvement services to people living in deprived communities, e.g. walk-in health assessments	Thank you for your comment, access to services is one of the key considerations in this scope..
4.3.1	*Birmingham Strategic Partnership*		We would like NICE to look into the benefits from mental health support as a component of interventions to improve lifestyles	Thank you for your comment. Unfortunately a specific focus on this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home However, should this issue arise within the remit of the revised scope, it will be considered.
4.3.1	*Birmingham Strategic Partnership*		We would like NICE to consider the health benefits associated with involvement in defined communities, including religious communities based on churches, mosques and Temples".	Thank you for your comment. The scope has been amended to include vulnerable or disadvantaged adults (wherever they live) as well as disadvantaged areas. Where these interventions fall within the remit of the revised scope, they will be considered.
4.3.1	*British Psychological Society*		It is vital that interventions are not just at the individual level.	Agreed. The focus of this scope is on proactive case finding, retention and access to services. In this context the outcome measures are concerned with service provision rather than the effectiveness of interventions per se.

4.3.1	*East of England Public Health Group*		Focus on current disadvantaged areas is understandable. However, regions like East of England, with significant growth targets, need to rapidly learn lessons about what does not work in making services accessible to the target groups in order to develop appropriate and accessible services in new communities in such a way as to prevent social disadvantage taking hold there too in the future	Thank you for your comments. Your point is noted and the review will consider evidence of what does not work as well as evidence of what does..
4.3.1	*East of England Public Health Group*		Focus on spearheads ignores rural deprivation	Thank you for your comment. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services .

4.3.1	*Heart of Birmingham PCT*		Evidence should examine a) interventions to improve the clinical management of people already on CHD /diabetes and renal disease registers in primary care – our audit of deaths of suggested that much scope remains to improve secondary prevention of those on these registers b) interventions to improve inclusion of people who have symptoms /signs of heart disease on CHD registers – because no incentives to do this under current QOF contract c) systematic approaches to primary prevention and case finding through primary care contractors ; how much it costs to adopt a population approach to identifiying all individuals over the age of 40 and undertaking a risk assessment /intervention . There are examples of the drugs industry funding such studies in general practice with additional prescribing of Statins etc + papers about how to prioritise target groups within the NSF requirements to ensure maximum health impact d) the best risk engines to use to case find and how these should be weighted to reflect additional risk of BME communities e) potential of community pharmacists to provide risk identification and risk management – recent evidence from Lloyds chemist trials suggest highly cost effective f) additional support and costs required to ensure education /compliance amongst low income /BME communities g) use of call centres to identify cases , call , schedule and follow up " case found "individuals . I believe the guidance should be drawn up jointly with the national screening service [Muir Gray } otherwise real tensions and scope to divert resources from what we are trying to do ie adopt a population based approach to case finding through improving mainstream service provision to ad hoc , minsterially suggested initiatives	Thank you for comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. We would be grateful if you could forward any literature on the topics that you have outlined. Thank you for suggestion regarding the National Screening Service. We will encourage them to become registered stakeholders and will take note of any guidance they have produced or are developing that has a bearing on this work.

4.3.1	*Institute of Health & Society, Newcastle University*		A further problem with the referral is highlighted here, because it is unclear whether the intervention approaches to be covered are actually effective at reducing premature death in disadvantaged areas. Should other approaches be explored as well? You will need to take care in finding the evidence, since the generic evidence on the approaches indicated (e.g. case finding) may not tell us how to use these approaches effectively in disadvantaged communities. You must avoid making assumptions about 'one-size-fits-all' in examining intervention evidence. There is considerable evidence that many aproahces to finding and intervening to prevent premature mortality lead to inequalities in outcomes (so called 'outcome-generated inequalities'. I have submitted a paper on this to NICE for the Behaviour Change PDG (White M, Adams J, Heywood P. How and why do interventions that increase health overall widen inequalities within populations? Babones S (Ed.). *From Equity to Health: International and Interdisciplinary Perspectives on the Link between Social Inequality and Human Health.* Baltimore: Johns Hopkins Press (*forthcoming*)), which summarise some of the evidence that will be of interest in this guidance – available on the NICE BC PDG web board.	Thank you for your comments, which are noted and agreed. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services
4.3.1	*Institute of Health & Society, Newcastle University*		Although there is considerable evidence relating to the interventions of interest, it is scattered across a wide range of research on different disease and risk topics, and there is a dearth of economic analyses, so far as I am aware. The systematic reviews may helpfully be complemented with some modelling of intervention effects and economics to determine the 'best buys'.	Thank you for your comments We are considering a number of approaches to searching the relevant literatures. When possible, the NICE process includes economic modelling..

4.3.1	*Institute of Health & Society, Newcastle University*		4.3.1 & 4.3.2- I think it will be important not to define the disease focuses too narrowly – for example, you may wish to include diabetes and obesity as key risk factors for these chronic NCDs. You may also wish to re-examine this before you start by looking at relative rather than absolute rates. Conditions with the widest inequalities may be an important focus for this exercise, rather than just those conditions which are most common. An example would be injury related deaths, which have very wide inequalities in some cases (e.g. house fires). Some sort of epidemiological analysis at the outset would help to tie this down.	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.3.1	*LB Newham*		As above should widen definition from purely NHS to include Local Strategic Partnership interventions. Many interventions are carried out in partnership in terms of planning, funding, delivery, can't separate out purely NHS elements. This is particularly important as the activities will include secondary prevention – as stated above, local authorities and other agencies may be much more involved in delivering secondary prevention than NHS organisations.	Thank you for your comment. Please see the revised scope which has been amended so that 'NHS led' interventions include agencies that work in collaboration with the NHS to meet this agenda.
4.3.1	*Southwark PCT*		As indicated above, although health trainers, health checks and outreach initiatives are valuable, it is important to look in greater detail at the GP contract to ensure that it responds adequately to the needs of disadvantaged populations. In particular a plethora of short-term initiatives is unlikely to produce the sustained gains we would all like to see and are vulnerable to budget panics.	Thank you for your comments, which we will pass to our Implementation team. Where evidence is available on the issues you raise, it will be considered in developing the guidance. .

4.3.1	*Southwark PCT*		Hypertension requires specific mention. Good protocols associated with hypertension identification and management will make a difference in the long run as well in the immediate future. This will not only impact on heart disease and stroke, but a number of other long term conditions, including some forms of dementia. We don't just want people to live longer; we want a higher quality life! It would be a pity if interventions suggested only dealt with the secondary prevention/attempted to meet short-term targets. One other issue too to note here- many intervention studies have quite short follow up periods. This will take some accommodation in the searches. Will you make full use of longitudinal studies (generally rather low in the hierarchy of evidence)?	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services The guidance will consider all appropriate evidence from these areas, including longitudinal studies. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.3.1	*Swimming World*		Define 'NHS interventions' to include those where a commercial partner is involved in the delivery of the intervention e.g. Slimming on Referral Programme	Thank you for your comments. The revised scope has been amended so that 'NHS led' interventions include agencies that work in collaboration with the NHS to meet this agenda.

4.3.1 a	*Boehringer Ingelhim Ltd*		▪ We welcome the focus on both primary and secondary prevention and welcome an approach to finding patients who are at higher than average risk of premature death and ensuring that they receive the most appropriate interventions. However we would also suggest including interventions that promote patient self management such as concordance with treatment, which in the target population will be a significant need. For example for secondary prevention there are data to suggest concordance to pharmacological treatment is poor. Research suggests that adherence with medication can be uncertain (Cox *et al* 2004) and possibly decline causing subsequent events (van Wijk *et al*, 2005) ▪ It is unclear from the draft scoping document whether the 'finding' of patients at risk of premature death will include proactive screening and risk assessment. Appropriate tools already exist which may be of particular value in those from high risk socioeconomic groups (e.g. SIGN 95). ▪ In addition there is evidence to suggest that risk of MI, TIA and stroke is highest in the morning (Mead, 2003). We would suggest that the scope of the guidance gives due cognizance to this fact which is also supported by data from the Met Office. Such information should inform proactive case and pharmacological management.	Thank you for your comments. The focus on service provision including access, recruitment, uptake and retention should include compliance. It would be helpful if you could submit or direct NICE towards the sources of information on the tools you have mentioned with regard to 'finding' patients at risk.
4.3.1 a	*Department of Health* * The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCM*S*		In our view, the list of examples should include using prevalence models to identify at a population level in a ward, GP practice or at higher resolutions such as a street or super output area the expected number of cases of the three key conditions of CVD, cancer and respiratory disease. Having identified an expected prevalence this can be compared with known prevalence to assist in the pro-active case finding. In our opinion, known environmental risk factors for specific diseases should also be explored for their potential to assist in case finding for example data on air pollution may assist in constructing models of prevalence of respiratory disease. Would you please include the following text "Known environmental risk factors for specific diseases should also be explored for their potential to assist in case finding for example data on air pollution may assist in constructing models of prevalence of respiratory disease".	Thank you for these helpful suggestions. We will pass them on to the teams undertaking the evidence reviews and search strategies.

Public Health Intervention Guidance

Health Inequalities Draft Scope Consultation – Stakeholder Response Table

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4.3.1 a	*Derbyshire County PCT*		Health trainers: experience from Derbyshire indicates that some of our health trainers are taking a client-centred approach rather than a behaviour change approach. For example: 'The experience opened my eyes to the complexity of people's problems, which no matter how straightforward a client's health needs seem at the outset, there is usually a deeper issue to address' (Quote form health trainer 1). 'A client came with low self esteem, jobless, facing homelessness with little support from family or friends. Over 2 months of regular meetings with me, he now lives in a rented flat with a part-time job and is attending college'. (quote from health trainer 2). In summary, clients are not in a position to change health behaviours until their immediate social and financial needs are addressed. Can this be explored and can it influence the future development of the health trainers' role so it becomes more responsive to clients' needs?	Thank you for your comment. It would be helpful if you could submit or direct NICE towards the sources of evidence on this point. You may also be interested in the developing NICE guidance on behaviour change, which addresses some of the issues you raise: http://guidance.nice.org.uk/page.aspx?o=BehaviourChangeMain NICE will also be recommending that future guidance be developed on population based approaches to tackling health inequalities.
4.3.1 a	*Royal College of General Practitioners (RCGP)*		Will need to consider medical workforce issues as in these areas majority of general practitioners will be retiring within the next 5-10 years. A number of initiatives such as physician assistants have been introduced these need to have longterm evaluation before wider implementation	Thank you for your comment., which we will pass to our Implementation team. Where evidence is available on the issues you raise, it will be considered in developing the guidance. .
4.3.1 a	*Royal College of General Practitioners (RCGP)*		Also need to consider facilities as majority of practices in targeted areas are working from inadequate facilities	Thank you for your comment. It would be useful if you could submit or direct NICE towards this evidence.
4.3.1 a	*Royal College of General Practitioners (RCGP)*		Average consultation length is shorter in these areas compared to suburban/rural practices with open surgeries in some practices.	Thank you for your comment. It would be useful if you could submit or direct NICE towards this evidence.
4.3.1 b	*Royal College of General Practitioners (RCGP)*		Would highlight translation/interpreting services	Thank you for your comment. All issues that have an impact on the areas outlined in the revised scope will be investigated.

4.3.1 b	*Derbyshire County PCT*		A project in Chesterfield called 'Communities that work' is funded by the Coalfields Regeneration Trust. This project targets unemployed people in ex-coal mining communities. Following initial meetings and organised events with agencies and residents and in conjunction with the community consultation exercise, a working group was established to design a core programme of work that would address the key issues. The working group was made up of the CRT, the PCT and Jobcentre Plus. Additional projects and proposals presented to the Trustees have been combined with the core activity to establish the final "Communities that Work!" programme approved by the Board on the 1st February 2006. Jobcentre plus and health workers cross-refer to ensure that people have easy access to services that meet their needs to allow them to take up employment opportunities. The project is being evaluated over the next two years. Early findings indicate that while referrals are lower than expected the project is reaching its target groups. Derbyshire County PCT's Smoking Cessation service reaches 'hard-to-reach' groups of smokers by running walk-in stop smoking clinics in deprived areas. It appears that people appreciate easy access to free NRT. Quit rates for this group are lower than average but not low for this population sub-group, at 30-38% at four weeks. 'Even for those who don't manage the 4 week quit target there is a real sense of achievement if they manage to quit for just one day'. (Quote from Stop Smoking service manager). Community development workers on deprived estates in Derbyshire towns are helping to increase the rate of breastfeeding by working with health visitors and local schools to run support groups for specific groups, e.g. young mums (under 25's). Infant and primary schools are good venues for these initiatives as parents are often there anyway.	Thank you for your comments and information. It would be useful if you could submit or direct NICE towards this evidence.

4.3.1 b (cont)	*Derbsyshire County PCT*		In areas of Derbyshire, weekly Citizens Advice Bureau sessions are run from GP surgeries. There is published evidence that this service reaches client groups that CABx fail to reach otherwise and that these groups include those with higher levels of illness and disability (Paris and Player BMJ 5th July 1993 pp1518-1520). There is evidence that this intervention delivers health gain, specifically improvements in mental health and vitality (SF-36 health domains) (Abbott and Hobby (2002) Research Report 87/02, Health and Community Care Research Unit, Liverpool University). The CAB provide help, support and advice on social and welfare benefit issues that has a positive impact on clients/patients' health. It is a relatively inexpensive intervention with a cost per client consultation of £27.38 and a cost per problem solved of £10.64 (contact: Julie Hirst, Derbyshire County PCT 01629-817931). This intervention is likely to address the social deprivation that causes many health inequalities (cf draft scope for guidance section 3 d)) In 2001 a participatory HNA was conducted of the agricultural population living in West Derbyshire Rural Development Area following concerns of the economic decline in local farming and the impact on health this might have. The HNA found worse health amongst local farmers than in people in socio-economic class five. This resulted in the establishment of a drop-in primary health care clinic providing walk-in access to a nurse, physiotherapist, primary mental health care worker, agricultural chaplain and Citizens Advice Bureau. Evaluation indicates this reaches and helps the 'hard-to-reach' agricultural & rural community who historically did not access mainstream primary health care services.	Thank you for your comments and information. It would be useful if you could submit or direct NICE towards this evidence.
4.3.1 b	*Sheffield PCT*		There was a view at the event that the focus on the NHS was too limiting. If I understood the brief correctly it may be worth changing the way this expressed in two ways. Firstly to include interventions commissioned or provided by the NHS. The second suggested change is to convey that this is <u>additional specific activity</u> as opposed to the provision of universal services. There may be a view that the solution is improving the quality of services to disadvantaged communities. This is an important component but should be expected of service providers anyway. It does not in itself reach those most susceptible and at risk.	Thank you for you comments. The scope has been amended so that 'NHS led' interventions include agencies that work in collaboration with the NHS to meet this agenda

4.3.1 b	*Surrey PCT*		Pleased that you have included community development interventions	Thank you. Please note that as a result of this consultation and discussions with the Public Health Intervention Advisory Committee the guidance will now focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription/use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.

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4.3.1 & 4.3.2	*UK Public Health Association*		The UKPHA has difficulty with the constant reference to the NHS. Neighbourhood- and population-based interventions must occur in partnership with local authorities and other partner bodies in the public, voluntary and community based sectors concerned with health and well-being. Sustainable Community Strategies led by LSPs emphasise this approach. Derek Wanless has referred to the fact that most people who are involved in promoting and protecting the health of the public do not even have 'health' in their title. Sir Michael Lyons' preliminary findings suggest that local authorities lack the confidence to claim their rightful inheritance as the promoters and facilitators of the public's health, because of the implicit dominance of the NHS all things 'health' related. This Guidance offers the opportunity for NICE to pave the way for acknowledging the role of the wider determinants of health and rejecting the NHS' clinically based models. The approach adopted to address inequalities appears to ignore the work of Michael Marmot, Richard Wilkinson and others that demonstrates that infant mortality and excess mortality from cancer, stroke and cardiovascular disease is directly related to social standing and feelings of autonomy and control. This suggests that strengthening disadvantaged communities by increasing social support, inclusion and participation to protect mental wellbeing (Choosing Health: making healthy choices easier p131) is as important, if not more important than proactive case finding , retention and improved access to services The way in which 'health inequalities' is perceived, framed, and addressed is crucial to successful outcomes. If addressing health inequalities merely entails service provision, it will be unsuccessful, and will miss out upon the invaluable scope of purposeful actions in communities in which the NHS has tremendous scope to be engaged. There are the skills, and the determination in many instances already. These must be supported, not constrained by reductionist, merely biomedical, or individualised approaches. The UKPHA is dismayed that NICE proposes specifically to exclude the wider determinants of health inequalities. Although it is acknowledged that macro-level policies aimed at tackling poverty and disadvantage cannot be addressed at the 'intervention' level, local area initiatives which recognise such wider determinants of health and set out to address them will achieve a far greater impact on reducing health inequalities by partnership working across all the sectors, communities and professionals involved.	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. 'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda. NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities as well as separate guidance for reducing infant mortality. NICE recognise the relationship between socio-economic group, mortality and moribidity for children and adults. All NICE public health guidance is concerned with reducing health inequalities. We acknowledge that the current guidance is limited to a particular set of approaches, but these approaches form part of a larger set of activities undertaken by the NHS and others. You may be interested in NICE guidance currently in development on community engagement

			The UKPHA is dismayed that NICE proposes specifically to exclude the wider determinants of health inequalities. Although it is acknowledged that macro-level policies aimed at tackling poverty and disadvantage cannot be addressed at the 'intervention' level, local area initiatives which recognise such wider determinants of health and set out to address them will achieve a far greater impact on reducing health inequalities by partnership working across all the sectors, communities and professionals involved. The narrow focus on NHS interventions is made all the more narrow by focusing only on targeted interventions aimed at people living in disadvantaged areas or aimed at adults with a higher than average risk of premature death from heart disease, stroke and cancer. It means that people may not submit evidence of NHS interventions that are universally available (i.e. not targeted)which have a disproportionate positive benefit to people in high risk groups.	(http://guidance.nice.org.uk/page.aspx?o=CommunityEngagement) and behaviour change (http://guidance.nice.org.uk/page.aspx?o=BehaviourChangeMain) which deal with some of the issues you raise. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.3.1 & 4.3.2 (cont.)	*UK Public Health Association*		Restricting the interventions to cancer and cardiovascular disease could be very limiting, considering that these are not the only chronic diseases linked to avoidable causes such as poor diet, physical inactivity and obesity. An effective primary prevention strategy, involving local partnerships and addressing a wide range of environmental, social and educational factors, would not only help with reducing the incidence of cancer and heart disease, but would also contribute to the general well-being of disadvantaged groups. (Kelly. M 2004 Health Development Agency The Evidence of effectiveness of public health interventions- and the implications.) suggests that local NHS interventions may be extended brief intevention. The NHS generally has limited access to peoples lives. Very little is achieved unless interventions are planned as part of a wider multi-agency strategy. A stronger emphasis is required on guidance for NHS professionals to be seen as part of the wider public health strategy. Health (and its equality) is not just a state of physical psychological and social well-being - there is a spiritual dimension to health that can be seen to over-arch all the other three classic Alma Ata factors from which we derive all our policies. Embracing a new look at this definition and how we should work with the spirit in all aspects of our planning and services is important in this regard. In Holland, Japan and some Scandinavian countries where there is more social integration and egalitarianism, the same great health inequalities are not witnessed. In addition our health service does not compare with any other major western European country, for example France or Germany. In terms of hospitals, intensive care beds, health outcomes for major diseases such as cancer or coronary heart disease our health service is on a par with Turkey or Mexico The scope needs to address the familiar problem of a mismatch between the topic and the available evidence helping to develop a framework for a range of approaches, which, given the complexity of the issues, may need to be considered simultaneously across a range of partners. An associated point is how much attention could be given to grey literature.	Thank you for your comments, which are noted. As a result of this consultation and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. We will pass your comments regarding the research process on to the centre who will be undertaking this work. NICE recognise the importance of meeting the PSA target on infant mortality in tackling health inequalities. Although infant mortality falls outside of the remit of this guidance, NICE will be recommending that separate guidance is developed in this area in the future. Additionally, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

			For areas where there appears to have been some success in narrowing the gap, the question is raised as to the level of evaluation considered acceptable for inclusion. This is particularly relevant for the mapping review and perhaps some clearer indication of the parameters of the mapping exercise and the distinction between mapping and primary research for the purposes of this review would be helpful. We question why NICE has left out the Tackling Health Inequalities indicator of infant mortality. This is where the largest ethnic health differences, for example, are found, whether the high risk population are babies whose mothers were born in Pakistan (Bradford) or whose families were Travellers.	
4.3.1 & 4.3.2 (cont.)	*UK Public Health Association*		The Neighbourhood Renewal Strategy illustrates this approach to tackle the wider determinants and improve mainstream services in employment, improved economic performance, reduced crime, better educational attainment, improved health, better housing and cleaner, safer, greener public spaces.	Thank you for your comment. NICE will recommend that future guidance be developed on population based approaches to reducing health inequalities.
4.3.2	*Heart of Birmingham PCT*		Although wider determinants are excluded there should be some examination of the impact of eg LA pricing policies , gender specific provision and subsidised transport eg passport for leisure schemes on uptake of healthy recreational activities , use of swimming pools , etc	Thank you for your comments. Please see our previous response: The guidance will focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.3.2	*Institute of Health & Society, Newcastle University*		Although wider determinants are excluded, you should be cautious about this, since these issues are part of the causal chain leading in the observed inequalities. Ultimately you can't ignore them. You will need to apply a sensible theoretical (causal) model for health inequalities in making sense of your findings (not just a descriptive device such as the Dahlgren and Whitehead rainbow).	Thank you for your comments. . As a result of this consultation and discussions with the Public Health Intervention Advisory Committee the guidance will now consider evidence on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins., NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities**.** You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.3.2	*National Childbirth Trust*		If infant, child and perinatal mortality are not to be covered, the title of the guideline should change to clarify the focus on adults only.	Thank you for your comment. The scope will be amended to reflect the target groups more clearly. NICE will also be recommending the development of future guidance to reduce infant mortality.
4.3.2 b	*British Psychological Society*		It is a very big mistake not to tackle wider determinants of health inequalities: macro policy change to reduce income inequality (a proxy for distribution of power to self determine) is the most effective way to address health inequalities.	Thank you for your comments. Unfortunately this is beyond the remit of this guidance. NICE will recommend that future guidance be developed on population based approaches to reducing health inequalities**.** You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.3.2 b	*Royal College of Nursing*		Whilst we recognise that the scope will not cover the wider determinants of health, these must be recognised in the guidance as it is widely understood that living conditions, housing, income, the environment etc all have an impact on health outcomes. Those who live in cities, for example are more likely to be affected by pollution from traffic as are those who live in close proximity to major transport links…..just one example.	Thank you for your comment. The scope makes reference to the broader determinants of health inequalities. NICE will recommend that future guidance be developed on population based approaches to reducing health inequalities and separate guidance for reducing infant mortality. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.3.2	*Southwark PCT*		This definition makes it sound as if mental illness will be excluded from the scope of the review. We would suggest that if the guidance is to be helpful, a holistic view is important and a mechanistic focus on bodily illness is unlikely to support best practice in prevention and treatment	Thank you for your comments. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.3.2 (a)	*Big Lottery Fund*		We are concerned that by limiting yourself to these areas you may lose out on important examples – for example HLCs are not likely to explicitly say that they are intending to reduce premature death – thy are more likely to say that they are trying to make people healthier.	As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. All issues that have an impact on the areas outlined in the revised scope will be investigated. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.3.2 (b)	*Big Lottery Fund*		These wider determinates are a major part of how healthy living centres and other centres of this kind work so you may miss important examples that give more qualitative measures.	Thank you for your comments. Please refer to our previous response. NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities**.**

4.3.2b)	*Royal College of General Practitioners (RCGP)*		Note that community development is included but in 4.3.1b) but the wider determinants of health are excluded. This does not make sense as this guidance will provide impetus to truly reflect 'joined-up thinking and working' to alleviate these premature diseases. Also in community development, the emphasis is not solely on NHS activities it is the wider determinants of health that also need to be addressed.	Thank you for your comment. Unfortunately tackling the wider determinants of health inequalities falls outside the remit for this scope and the development of intervention guidance. However, NICE will recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality. The scope has been amended so that 'NHS led' interventions include agencies that work in collaboration with the NHS to meet this agenda. You may also be interested in NICE guidance currently in development, on community engagement: http://guidance.nice.org.uk/page.aspx?o=CommunityEngagement

4.4.1	*Institute of Health & Society, Newcastle University*		Gathering evidence on all of these groups will require a wide range of search strategies. It would be beneficial for groups conducting searches to compare strategies and findings before the reviews are written up, so as to capture all of the relevant material and avoid repetition.	Thank you for your comment. As a result of this consultation and discussion with the Public Health Intervention Advisory Committee the scope has been amended and will focus on smoking cessation services and prescription/use of statins. The literature searches will all be carried out by our collaborating centre at the University of Cardiff, in collaboration with information colleagues at NICE. We are considering different approaches to identifying relevant literature, and will pass your comment on to the team.
4.5	*Brighton & Hove City PCT*		When considering making recommendations regarding the QOF it is important to appreciate that the exception reporting process, which allows GPs to exclude individuals from their denominator used for payment, is likely to be excluding the very people this guidance is likely to help.	Thank you for this comment. We will pass your comment on to our implementation team. You are also encouraged to give feedback on this issue when the draft guidance goes out for consultation.
4.5	*British Psychological Society*		Are the service use outcomes the primary outcome rather than health? Outcomes must include some subjective measures from disadvantaged patients who are receiving these services. It cannot be automatically assumed that the actions proposed will necessarily improve subjective quality of life. This needs to be assessed systematically and could be done using a generic assessment e.g. WHOQOL-Bref, on-line (www.bath.ac.uk/whoqol). Unless health-related quality of life is significantly improved by interventions administered to those who are identified as disadvantaged, there will be insufficient motivation for them either to continue to attend needed consultations or to persist with recommended behaviours that are needed to improve their health. Also, given the focus on disadvantaged groups, what will the comparisons be?	This guidance will focus on service provision including access, recruitment, uptake, retention and other process measures as outcomes. Where we find appropriate evidence on the issues you raise, it will be considered. The comparisons, where there is evidence available, will be drawn against service use / uptake and other process measures where efforts have not been made regarding proactive case finding, retention and access.

4.5	*Institute of Health & Society, Newcastle University*		Since premature mortality is mentioned in the scope, it should surely be explored as an outcome? What about risk factors for premature mortality?	Thank you for your comment. As indicated above the focus for this guidance will be service provision including access, recruitment, uptake, retention and other process measures as outcomes rather than the effectiveness of interventions for tackling risk factors for premature mortality.
4.3.2	*Southwark PCT*		*This definition makes it sound as if mental illness will be excluded from the scope of the review. We would suggest that if the guidance is to be helpful, a holistic view is important and a mechanistic focus on bodily illness is unlikely to support best practice in prevention and treatment*	Thank you for your comments. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.5	*LB Newham*		Is it possible for the outcomes to include impact measures, for example, actual reductions in smoking prevalence, measurable behaviour change, not just service reach?	Thank you for your comments. The outcomes of interest to this guidance, given the referral from the Department of Health, will primarily be measures of service provision including access, recruitment, uptake and retention and other associated measures rather than the effectiveness of the intervention per se. Other areas of NICE guidance will address some of the issues that you raise: http://guidance.nice.org.uk/type . You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.5	*NHS Health Scotland*		It would be desirable to add specific reference to maintenance (of engagement and participation) and concordance (with advice, treatment etc).	Thank you for your comment. All issues that have an impact on the areas outlined in the revised scope will be investigated. We consider that maintenance of engagement and participation is covered by the term 'retention' but we will add these specific terms to the scope.
4.5	*QUIT- European Network of QUITlines*		Outcomes There should be a measure showing how these services are promoted within these areas and a measure showing how "relevant" the staff are (by way of training and knowledge, skills and attitudes) [see recommendations made by Mason S et al Representation of South Asian people in randomised clinical trials: analysis of trials' data (BMJ 2003;326:1244-1245)	Thank you for you comments. All issues that have an impact on the areas outlined in the revised scope will be investigated.
4.5	*Royal College of General Practitioners (RCGP)*		In addition to use, accessibility and availability, quality of services has also to feature	Thank you for your comment. We agree – 'quality of service' is covered in the key questions.
4.5 (and 4.6)	*Sheffield PCT*		An important additional outcome for service reach is the timely engagement of individuals. In Sheffield we are currently exploring whether we can identify a measure of prognosis/severity of disease at the time of initial engagement with services. This is in recognition of the importance of reaching people earlier to maximise potential benefit from earlier intervention.	Thank you for your comment. We would be grateful if you could provide NICE with your findings and the details of any literature.
4.5	*Southwark PCT*		*We would suggest: 'how services identify AND RESPOND TO, the needs of population subgroups.*	Thank you for you comment.
4.5	*Stoke on Trent PCT*		Section 4.5 outcomes. Page 6 As a third bullet point to "Outcome measures of service reach" to include 'sustainability'??	Thank you for your comment.
4.6	*Big Lottery Fund*		Healthy Living Centres can provide examples for all the questions set out here. HLCs provide services based on local needs, working with PCTs and other organisations – users are self-referred and referred by GPs and other statutory and voluntary services – but the main point is that they exist purely to meet local needs of the community and can respond quickly to changing needs – they can often be much more cost effective than statutory services.	Thank you for your comment. All issues that have an impact on the areas outlined in the revised scope will be investigated. If you have evidence that is relevant to this area, we would be grateful if you could submit it for our consideration.
4.6	*Birmingham Strategic Partnership*		When gathering data from PCTs about interventions it would be helpful to chart the impact against: (i) per capita health spend; (ii) % growth in NHS spend over the period being considered	Thank you for you comments. All issues that have an impact on the areas outlined in the revised scope will be investigated.

4.6	*Boehringer Ingelheim Ltd*		Key Questions: ▪ We recognise the remit of NICE is to focus primarily on health and that the scope of guidance is not intended to look at the macro and wider determinants of health. We would suggest however that consideration is given to including other stakeholders in supporting the delivery of this guidance such as: o Local authorities' responsibilities in supporting access to services, information and education. For example supporting rehabilitation, exercise programmes, transport policies, education and translation services, etc o The third sector as providers of services and of information, advocacy and advice. ▪ Public health we believe is about empowering communities as well as individuals and therefore the responsibility for the delivery of the guidance lies beyond purely healthcare organisations. When discussing treatment it is important to highlight that individuals should be offered the most appropriate treatment for them, given that there is strong evidence of ethnic variability in treatment efficacy.	Thank you for your comments. The scope will be amended to include agencies that work in collaboration with the NHS to meet 'NHS led' agendas. You may also be interested in related NICE guidance on community engagement, physical activity and behaviour change, which can be accessed by visiting: http://guidance.nice.org.uk/page.aspx?o=PHPGID.
4.6	*British Heart Foundation*		Given the original referral from the DH, we would like to see these questions framed in terms of PCTs partnership with local authorities and third sector organisations. Given the evidence that suggests that some public health interventions may inadvertently widen inequalities, an additional question could ask for evidence on successful processes to help ensure that interventions do not unintentionally widen inequalities. A considerable amount of work has been done on this in regard to risk assessment in cardiovascular disease and the subsequent inclusion of deprivation in SIGN guidance in Scotland.	Thank you for your comments. The scope will be amended to include agencies that work in collaboration with the NHS to meet 'NHS led' agendas. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
4.6	*British Psychological Society*		The key questions look good but very challenging.	Thank you.
4.6	*Department of Health* **** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS***		In addition to the comments above, we are unsure why the key questions are framed in relation to only the PCT. It is our view, that the key questions should be expanded to include a wider range of health providers including the acute sector, pharmacies, GPs, Dentists, Occupational Health services etc.	Agreed. The key questions have been amended as a result of this consultation and discussions with the independent Public Health Intervention Advisory Committee responsible for developing the recommendations.
4.6	*NHS Health Scotland*		Some of the comments above will, if acted upon, have a bearing on the 'Key questions'.	Noted, thank you.

4.6	*NHS London*		I couldn't see anything particular about retention of people once they have accessed services. I think it worth pulling out as it is likely to be an issue in its own right Also I think it worth finding out if PCTs have been successful with specific ethnic minority communities. They have high rates of CHD and may well have different issues relating to finding, access and retention I wondered if it was worth looking at the workforce and seeing if there are particular issues there that are of help in designing effective services	Thank you for your comments.. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.6	*QUIT- European Network of QUITlines*		Key Questions 1) A key question should be how the services get the "relevant" staff (by way of training and knowledge, skills and attitudes). Recruitment of staff that have no idea and clue about the population they serve is a key problem (NHS recruitment is key to get the people with the right cultural, social, linguistic and political awareness to target these key spearheads) 2) The second key question should be: How rich is the local social capital and how has the service (NHS) engaged the non-profit and other civil society in local health	Thank you for your comments. T As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda.,You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

4.6	*Royal College of General Practitioners (RCGP)*		Referring to earlier comment (4.1.1) about age cut-offs, need to clarify what we mean by adults	As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.The age groups will be determined by the evidence that is located on service users.
4.6	*Royal College of Nursing*		One question to PCTs, who are now charged with working more closely and in collaboration with local authorities and other agencies, would be 'how can PCTs best develop collaborative partnerships with other organisations/agencies to ensure that interventions are effective across the population?' In all Government policy documents, there are repeated messages to indicate that health cannot tackle these 'big killers' on their own …they must be in partnership for any successful outcomes.	Thank you for your comments. We recognise and appreciate that there are a number of different organisations that have an impact on inequalities. We will review the scope to ensure that it includes other organisations outside the NHS**.**

4.6	*Sheffield PCT*		I believe the first key question should change to include the word 'systematically'. "How do PCTs *systematically* seek out and support adults with higher than average risk …" However as stated earlier the focus I believe should be targeting the under 65 population at risk.	As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda. Clearly, this approach will consider evidence on systematic and ad-hoc attempts to seek out and support vulnerable adults, where it is available.
4.6	*Sheffield PCT*		I believe a number of us at the event indicated the importance of data collection, for example ethnicity recording. This is particularly important in GP practices. The quality and accuracy of data held on their lists and registers could provide a cost effective means of identifying at risk individuals and informing targeted interventions within communities. This will however be dependent on the registers including the population at risk and a reduction in the number of exceptions recorded through the QoF process. The maintenance of up to date accurate records may also enable people to be signposted onto other initiatives that will impact on health. For example knowing that the individual is on incapacity benefit and referring into the Pathways to Work programme.	Thank you for your comment. All issues that have an impact on the areas outlined in the revised scope will be investigated**.**

4.6	*Southwark PCT*		*We would suggest extending the questions:* *How can partner agencies help the NHS to do this (Local authorities, Voluntary and Private Sector)* *How can communities and individuals be more involved and invested in what is delivered? (Without such involvement, there is no meaningful and sustained long term change, simply a flurry of glossy initiatives whose appeal and funding soon vanish).* *How can we help communities to value free services and respect the fact that they need to commit effort and time to working with them?* *How can activity be sustained/linked to employment opportunities/social enterprise/user run and led services?*	Thank you for your comments. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. The scope will be amended to ensure it includes these other organisations. You may be interested in NICE guidance currently in development on community engagement and behaviour change, which relate to some of the issues that you raise: http://guidance.nice.org.uk/page.aspx?o=PHPGID . 'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda.

4.6	*UK Public Health Association*		Bearing in mind the above, these questions should be framed in the context of partnership working with local authorities and other neighbourhood based bodies and organisations The key questions seem to have been framed around a very traditional and 'old fashioned' view of public health, which given the continuing increase in health inequalities, has not served us well. PCTs do certainly have a role in identifying individuals, groups and communities at risk but should be providing 'support' in partnership with other sectors. Similarly it might be better to specifically ask what strategies/ action PCTs take to engage other sectors and what has been achieved, as well as the same set of questions about the communities themselves. As the questions are currently phrased it would be possible to omit these vital aspects. Because of this it would be better also to explicitly talk of 'services' in terms of NHS run services, local authority run services, voluntary sector run services, independently run services and community run services. A further key question should be; "What evidence exists about the relative benefits of group and community based interventions to reduce inequalities as opposed to individual interventions?" The questions need to take into account current policy direction which could see commissioning with organisations such as social enterprises, what is the best way for these organisations to work together in case finding.	Thank you for your comment.: we agree and the scope will be amended to ensure that it include agencies that work in collaboration with the NHS to meet the inequalities agenda. Please see previous responses re: revisions to the scope.
4.7	*Brighton & Hove City PCT*		By the time the guidance is published Practice Based commissioning will be another year further on. Health Inequalities is an area that some GPs consider is not an issue for them to tackle. It is therefore important that the guidance is not just aimed at PCTs but at the GPs and Practice Based commissioning groups as well.	Thank you for your comments, which we have noted. We will also pass them on to our implementation team .

4.7	*British Heart Foundation*		Again the BHF is concerned that the scope is too narrowly focused on NHS professionals. We appreciate the need to produce a manageable document but are concerned that in this era of LAAs, LSPs and social enterprises, this is precisely the wrong time to be excluding the local authorities and third sector public health workforce.	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda.
4.7	*British Psychological Society*		The guidance needs to engage with community activists and community members	Thank you for your comment. We agree and the scope will be amended.

4.7	*College of Occupational Therapists*		We would hope that the guidance would be of use to a wider range of professionals and NGO's rather than just those working in the NHS. Surely public health change requires the contribution from a broad spectrum of stakeholders, which would include those outside the NHS.	Noted. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda.
4.7	*Department of Health* **** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS***		Would you please give consideration to widening the target audience group to include LA's, commissioners, voluntary and third sector.	Thank you. As indicated above, where appropriate, this guidance will extend to organisations working outside of or in partnership with the NHS, if their work impacts on health inequalities.
4.7	*LB Newham*		Comments as above, audience should be wider to include public health professionals and wider public health workforce as part of Local Strategic Partnerships. In local government terms it might include people with responsibility for developing regeneration and neighbourhood renewal programmes, secondary prevention programmes, healthy workforces interventions etc.	Noted. Thank you for your comment. We agree and the scope will be amended.
4.7	*NHS Health Scotland*		See 'General 2' comment regarding services outwith the NHS.	We agree. Thank you for your comment. The scope will be amended.

4.7	*Royal College of General Practitioners (RCGP)*		Is the Guidance solely is aimed at NHS or is a systematic approach advocated involving PCTs, LAs and others as defined in 3f	Thank you for your comment. The guidance is aimed at all who have an impact on the topics raised in the revised scope, which include the bodies you have outlined.
4.7	*Southwark PCT*		*Can we afford to exclude our local authorities, voluntary sector partners who are involved in delivery from this guidance? There is a change that this guidance might retreat back to the silo mentality and perpetuate the concept of the NH as a 'sickness' service rather than a 'wellness' one.*	Noted. Thank you for your comments. The scope will be amended to ensure that it includes other organisations outside the NHS.
4.7	*Surrey PCT*		You only mention that the guidance is aimed at the NHS, whereas the DH brief included "other sectors"	Noted. Thank you for your comments. The scope will be amended to ensure that it includes other organisations outside the NHS.
4.7	*UK Public Health Association*		The Guidance should be aimed at professionals working in the NHS in partnership with other professionals and workers involved with reducing premature death and improving the quality of life of disadvantaged communities. This should be set within the context of the LAAs and coordinated through the LSPs. Given the development of Local Area Agreements and the fact that Wellbeing and Health Partnerships are about to become statutory bodies under the auspices of Local Authorities then the guidance ought to be directed at local authority and voluntary sector staff as well as NHS staff. This is a crucial matter for LAAs, including local government, health and voluntary sectors (and probably private sector too). Staff attitudes and engagement with the intervention is fundamental as are relationships between health services and other local government, schools, voluntary organisations and partners from NGOs as well as local political buy-in. (Kelly M. 2004 Director of Evidence and Guidance Health Development Agency). The approach to commissioning health services through local communities and the Third Sector further emphasises why partnership working should be at the forefront of NICE guidance.	Noted. Thank you for your comments. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS. and the scope will be amended. We will also pass your comments on to our implementation team.

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Appendix A	*LB Newham*		We note that the referral from the DoH referred to "guidance to the NHS and other sectors …"	Noted. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.'NHS led' interventions will include agencies that work in collaboration with the NHS to meet this agenda.

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General	*Big Lottery Fund*		The Big Lottery Fund's Healthy Living Centre (HLC) programme was set up in conjunction with DH and other regional and local health stakeholders in 1999 to help tackle health inequalities – the majority as based within the 88 spearhead PCTs. You may wish to look at our evaluation of the programme to support your guidance. The evaluation of the programme has found a variety of evidence to show that the programme was achieving its primary objectives of contributing to the health and wellbeing of people in deprived areas, and in helping to address health inequalities. The breadth of these goals - of including both health and wellbeing in the programme aims – meant that HLCs ran holistic programmes of activities that combined both health and social benefits. These holistic programmes were key to engaging people from harder-to-reach communities, who might not otherwise come forward to take part in health related activities. HLCs can make an important contribution to reaching health inequalities targets, by developing and supporting a range of activities which provide multiple opportunities for people in deprived communities to improve their health and wellbeing. What is a HLC? One of the continuing challenges for the evaluation has been to provide an adequate description of what constitutes a 'healthy living centre'. This is an important question in terms of contributing to the evidence base for tackling health inequalities, since if the nature of the intervention is unclear, then it is unclear what it is that is having an impact. HLCs vary from one to another in many ways, and one key difference between centres was the way in which they interpreted the concept of health inequalities, and which of the several causes of health inequalities they felt was particularly pertinent in their communities.	Thank you for your comment. We would be grateful if you could submit or direct NICE to your evaluation of the HLC programme.

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General	*Big Lottery Fund*		How HLCs have tackled health inequalities Providing evidence of effectiveness in tackling health inequalities is difficult – and has been the subject of a considerable amount of literature. A key issue in the HLC programme has been the variety of interpretations of what actually constitutes health inequalities, the variety of explanations of what constitute the 'cause' of health inequalities, and consequently what constitutes an appropriate 'solution'. One of the features of this programme is that it emerged out of a policy environment that for a move away from too much emphasis on the health behaviour of individuals, and towards a more systemic view of health inequalities. In the early stages of the evaluation, the evaluators identified seven different and commonly used explanations of health inequalities: • A behavioural or lifestyle explanation: poor health arises from individual lifestyle factors such as lack of exercise and poor diet. • A service appropriateness explanation: variations in health arise because of a lack of culturally appropriate services and opportunities in some areas. • A service accessibility explanation: variations in health arise because no services are available, or people are unable to access the services. • A community participation/involvement explanation: services are inappropriate or inadequate because of lack of community involvement or consultation. • A social exclusion/social capital explanation: poor health in parts of the population arise because of structural factors: age, sex, culture, race/ethnicity. • A poverty and income explanation: poor health is related to poverty and unemployment in key sectors of the population. • An environmental explanation: poor health arises because of poor environmental quality – housing, available green space, poor air quality etc.	Thank you for your comment. We would be grateful if you could submit evidence on the issues that you raise to NICE, for our consideration.

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General	*Big Lottery Fund*		The activities planned by HLCs in their initial applications could be broadly clustered around the different strategies adopted in tackling health inequalities: • *Focus on specific health issues, lack of access to information, interest and confidence*: most centres provide health information, help people address risky behaviours such as smoking, drinking and drug–taking, and create new opportunities for physical exercise and healthy eating. General empowerment and support is an important part of these activities. • *Addressing lack of access to conventional services*: many provide new ways of accessing health care, as well as new services such as support and counselling for vulnerable groups, and activities for parents and children. These are often provided in conjunction with other agencies. • *Addressing social exclusion and isolation*: most address this through provision of social activities, outreach to more 'hard to reach' groups, and community development activities • *Addressing underlying poverty and environmental issues*: many seek to address unemployment and poverty through providing training and education (including volunteering schemes), advice and information, and specific activities such as setting up credit unions.	Thank you for your comment. It would be useful if you could submit or direct NICE towards the sources of this information.
General	*Big Lottery Fund*		A key feature of the HLC programme in the approach to health is a holistic one. Although some tended to focus their activities more strongly in one area or another, most centres had a wide range of activities that addressed several different categories of 'health inequality causes'.	Noted. Thank you. The narrow focus of intervention guidance precludes the possibility of addressing a wide range of determinants of health inequalities, NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality.

General	*Big Lottery Fund*		Regarding users of HLCs, and in terms of addressing health inequalities, a key question is not how many people the HLC has reached, but who – and how that reflects the vulnerable sections of their communities. The success of HLCs in reaching their target groups has been mixed – some have been very successful and others have had difficulty in generating local interest. The overall value for money of any HLC will depend on its success in attracting targeted population groups to its activities. Public health interventions will not address health inequalities – and will not be cost effective – if they primarily attract the sectors of society that already enjoy good health. Although there is some debate about the causes of health inequalities, two key factors that have been demonstrated to have a close link with health inequalities (The Acheson Inquiry) are poverty and unemployment, and poor access to health services (DoH 2002). While few HLCs have set out to provide evidence of their impact on poverty or unemployment amongst users of their activities, many have provided specific training opportunities, often via volunteering opportunities, as well as help and advice with benefits, debt and other key factors related to poverty. Several stories of users about their experience of an HLC closely link the help that they received from attending HLC activities, a growing level of confidence and wellbeing, and being able to seek work, often after many years of unemployment (for some stories/examples, see Final Evaluation Report). The contribution to health inequalities of the lack of accessible services has been commented on by both the Department of Health (2002) and the Disability Rights Commission (2006). Trying to improve the level of services available to their target population was an important part of the work undertaken by HLCs, alongside their general work on mobilising the community and encouraging local people to develop new activities for themselves. Some HLCs set up new services either by themselves, or as a joint project with another local organisation – perhaps one of their partners, or local health professionals. Many also took steps to identify gaps in services, and to mobilise other organisations to fill these, sometimes acting as a lobby on behalf of their target groups. They also had a role, via their partnership structures, in bringing together a number of diverse organisations in a more coordinated response to health and wellbeing related issues in their area, or in encouraging other local agencies to provide more sympathetic and accessible services. This aspect of their work also relates to the move, taking place in all parts of the UK, to create a stronger working relationship between statutory, voluntary and community organisations in meeting the needs of local communities.	Thank you for your comment. It would be useful if you could submit or direct NICE towards the sources of this information.

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General	*Big Lottery Fund*		Some broad lessons for policy makers For those in the policy arena, the most important lessons that emerge from the implementation of the programme concern the challenging nature of work at the 'coal face' of addressing health inequalities. No simple 'models' or 'formulas' for action emerge from this programme – each centre had to learn for itself what was the best approach, and most suitable activities, for their particular target audience. For those in the public health policy field, the programme demonstrates that a broad health agenda can be a useful device in encouraging innovative solutions to entrenched public health problems at a local level. This combined with relatively 'open ended' funding. It enabled HLCs to develop a range of activities that were both mutually supporting, and provided a range of options for those approaching them. However, it is important to learn that reaching 'hard to reach' sections of the community and engaging communities in health developments of this kind is likely to require more than just 'activities' – resources will also need to be invested in outreach, building links with the organisations already working in the community, establishing trust and commitment. Most of all, it requires a 'platform' from which this work can be undertaken.	Noted. Thank you for your comment. It would be useful if you could submit or direct NICE towards the sources of this information.
General	*Birmingham Strategic Partnership*		This document will be useful for partners who are involved in public health and health improvement as well as the NHS	Thank you.
General	*Boehringer Ingelheim Ltd*		The title is "tackling health inequalities" and the guidance is aimed at reducing the health gap between the disadvantaged and the rest of the population. Although it states that this will encompass effective and cost-effective methods of identifying disadvantaged patients. There is no mention of equity vs. efficiency, i.e. does cost-effective in one group of patients and fair necessarily mean optimal?	Noted. Thank you for your comment. The issue around equity versus efficiency will be considered in the course of developing the guidance.
General	*Boehringer Ingelheim Ltd*		We understand that this might be covered in the full guideline we believe that this document should at least consider the possible trade-offs between equity and efficiency (i.e. capacity to benefit ~ cf. Culyer and Wagstaff 1992). In addition, it may be appropriate to also consider opportunity cost.	Thank you for your comment. Opportunity cost of interventions and recommendations is covered as part of the economic and cost-effectiveness review.

General	*Boehringer Ingelheim Ltd*		We welcome the focus on a public health approach to managing premature death from cardiovascular disease particularly for those living in disadvantaged areas. As a company BI has worked with NHS managers and healthcare professionals to work towards reducing the burden of disease through prevention, promoting social responsibility through education, self management in secondary prevention, and tackling the causes of cardiovascular disease and we are aware of the particular challenge that social inequality presents.	Thank you. It would be useful if you could submit or direct NICE towards any relevant sources of information.
General	*Boehringer Ingelheim Ltd*		This guidance provides is an excellent opportunity to target and provide proactive management of chronic disease in disadvantaged population. However, we would welcome further clarity regarding the specific disease areas this will be covering.	Thank you. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.
General	*Boehringer Ingelheim Ltd*		We would suggest both medicines management and lifestyle interventions should also be explicitly covered in this guidance, since this will reduce the overall risk of premature death (SIGN 97).	Thank you for your comments. Please see our previous response regarding amendments to the scope.
General	*Boehringer Ingelheim Ltd*		It is unclear from this draft scoping document how broad the determinants of heart disease, cancer and stroke will be. Currently better management of hypertension, AF, TIAs and cancer are modelled for primary care in the Quality and Outcomes Framework (QoF). We would suggest that the scope of this guidance seeks to support and inform the QoF.	Thank you for your comments: Please see our previous responses re: the revised scope. We will pass your comment on the QoF on to our colleagues in implementation.
General	*Boehringer Ingelheim Ltd*		The scope of the guidance appears to promote a patient focus. SIGN recommends for such information should promote partner and family inclusion (SIGN 93). Carers are particularly vulnerable, often being asked to care for relatives without feeling they have the expertise or understanding to manage pain control or the administration of medicines.	Thank you for your comments. We agree. The scope will be amended to be more inclusive and consider all bodies that have a potential impact..

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General	*Boehringer Ingelheim Ltd*		In addition the policy of plurality of provider in England suggests that new guidance should be considered with regard to the new contractual nature of service provision and ensure that service standards and quality of provision for the most vulnerable groups are incorporated into local planning and commissioning.	Noted. Thank you for your comment.
General	*Brighton & Hove City PCT*		Given the level of cutbacks in Health Promotion and Public health teams many PCTs are currently experiencing we have some concerns around who will be implementing the guidance when it appears.	Thank you for you comments. The guidance is aimed at all NHS professionals and agencies that work in collaboration with the NHS to meet 'NHS led' agendas on addressing inequalities. The recommendations aim to provide evidence-based guidance for best practice.
General	*British Heart Foundation*		The BHF welcomes the attention that NICE is giving the inequalities agenda. In future it may be useful to consider how work to reduce inequalities can be integrated into all public health intervention guidance. For example, what public health interventions are more likely to reduce inequalities within workplace health or preventing STDs and under-18 conceptions. Such an approach would help ingrain the idea that good public health is as much about reducing inequalities as it is about improving population health. However, the BHF is disappointed that the original referral from the DH was narrowed from "guidance for the NHS and other sectors" to focus solely on NHS interventions. Given the increasing mandate of local authorities to tackle health inequalities, this seems like an excellent time to produce practical guidance that local authorities and third sector organisations can also implement.	Noted. Thank you for your comments. Reducing health inequalities is currently considered a key question across all NICE guidance. The scope will be amended to include all NHS professionals and agencies that work in partnership with the NHS to meet NHS-lead work on health inequalities. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*British Psychological Society*		We welcome the fact that NICE is addressing the important issue of health inequalities. We recognise that this proposal aims to focus on the potential actions that are open to health services. It seems surprising not to see any mention of the potential role of wider actions such as promoting educational participation, community cohesion, safe environments, etc. It might be helpful to frame this guidance within a framework of wider determinants. It was most regrettable that the BPS did not have a voice at the stakeholder meeting on 8 Feb as psycho-social processes are a vital issue for public health intervention. Public health psychology / community psychology is increasingly recognised as an important contributor to the public health debate and should be included. As George Albee pointed out, no mass disorder has ever been eliminated by treating people who are ill: Primary prevention is necessary to reduce premature death. It is clear that disproportionately negative rates of premature death occur amongst the poorest and least powerful people in the country: the exclusion of macro-intervention to address poverty and powerlessness means that the most effective forms of public health intervention are ruled out. Premature death cannot be tackled without addressing the unjust societal structuring of power to self determine (for which there are many proxies in terms of low income, poor educational outcomes, poor housing etc). Premature death cannot be addressed by 'doing things to' people but requires collaborative participatory action. Some of the effective and inspiring public health developments have been collaborations between community activists like Mrs Cathy McCormack and health professionals e.g. the Scottish damp housing project. Premature death has a complex multi-level aetiology to which psycho-social processes are absolutely central. Effective public health intervention requires psycho-social expertise. Any public health intervention necessarily has implicit political and ideological dimensions, recognised or not. It is vital to engage in critical scrutiny of these dimensions.	Thank you for your comments. NICE recognise the value of perspectives from public health and community psychology in developing guidance, and the BPS have been involved as stakeholders in a number of our work areas. For example, you may be interested in NICE guidance currently in development on community engagement and behaviour change, which relate to some of the issues that you raise: http://guidance.nice.org.uk/page.aspx?o=PHPGID . Unfortunately tackling the broader determinants of health inequalities is beyond the remit for this scope and the development of intervention guidance. However NICE will recommend that future guidance be developed on population based approaches to reducing health inequalities**.** You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

			Many if not most public health interventions proposed in contemporary times are individualistic and reactive. These are victim blaming and alienating for members of communities most affected (they do not only experience high morbidity and mortality but also get blamed for it too) Public health interventions based upon health education (jog, eat brown bread, stop smoking), individual one to one intervention (health trainers, health checks) and access (walk in and drop by centres) are treated with derision by many in our most disadvantaged communities. o One of the more invidious sorts of public health intervention involves cognitive behaviour therapy because it repositions socially causes problems as causes by individual intra-psychic	
General	*British Psychological Society*		The issue about developing more accessible services is not one simply about physical location of the services but also about the philosophy underpinning them. NHS services need to move away from a disease based public health model and to adopt a more psychosocial approach. A good model is that developed by a clinical psychologist Sue Holland in the 1980s on a deprived estate in Hammersmith, London (White City Project) which linked individual psychotherapeutic intervention with social action *(Holland, S. (1988) Defining and experimenting with prevention: In Ramon and Giannichedda (Eds) Psychiatry in transition: British and Italian experiences).* Community development approaches cannot simply be grafted onto existing NHS provision without a shift in thinking by NHS providers. Training is needed for staff in psychosocial approaches and in participatory approaches. This is about letting people define the problem and working with them.	Noted, thank you. Please see our previous response. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*British Psychological Society*		There is a need for collaborative primary prevention involving members of disadvantaged communities and colleagues from a range of disciplines including community psychology to engage in trans-disciplinary innovative participatory action research to address premature death and indeed morbidity and distress in our most disadvantaged communities.	Thank you for your comment. Please see our previous response.

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General	*British Psychological Society*		There is no mention of action at a family level by PCTs; only individual patients. This focus misses a wider opportunity to influence the health of the broader community. There is good empirical research to demonstrate the transgenerational transmission of attitudes towards health and health care, and health behaviours. PCT teams could be encouraged to promote health beyond the individual consultation, and family outcomes measured.	Noted: please see our previous responses. It also would be useful if you could submit or direct NICE towards the sources of information.
General	*British Psychological Society*		Cultural and subcultural views of health and health care make a profound difference to whether people perceive their health as problematic, and whether this is then acted upon. Any generic recommendations made to PCTs will need to be accompanied by specifics that could assist them in adjusting their actions appropriately to target particular subgroups in their own disadvantaged populations. These will differ considerably according to region and location. We suggest that research findings are brought together about health and health care actions in each of the disadvantaged subgroups to be selected and used by PCTs as a supplementary optional menu.	Noted. Thank you for your comments and suggestions.
General	*College of Occupational Therapists*		We are concerned that the scope of this document appears to be constrained by the fact that it is commissioned by the DOH and therefore is seen as offering advice to the NHS. It appears to be a limiting document designed to scope what is currently happening in PCTs rather than taking the opportunity to look at wider public health interventions.	Noted. Thank you for your comments. Unfortunately tackling the broader determinants of health falls outside the remit of this scope. NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		Addressing Health Inequalities continues to be one of the top priorities for both Government, Local Government, and the NHS and we welcome the development of this intervention guidance. We accept that intervention guidance has to be more limited in its scope than Public Health Programme guidance. We feel that the development of this intervention guidance may highlight the need for future consideration of Health Inequalities Programme Guidance. Such Programme Guidance would enable consideration of the role of wider determinants on health inequalities- which although important to addressing health inequalities we agree are outside of the scope of the development of this guidance.	Thank you for your comments. NICE recognises the importance of the wider determinants of inequalities in health. This has gone forward as a suggestion to the topic consideration panel. NICE will also put forward a suggestion that future guidance be developed on reducing infant mortality.
General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		We accept that the scope needs to be limited to adults to enable the guidance to be sufficiently focused and deliverable but we feel the contribution of these interventions to reducing infant mortality rates (e.g. reducing smoking in pregnancy, reducing obesity rates in preconception mothers). Would you consider making reference in the scope?	NICE recognises the importance of tackling the wider determinants of inequalities in health and reducing infant mortality. These issues have gone forward as suggestions to the topic consideration panel. The scope will be amended to reflect these actions.
General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		It is important that the economic modelling of the “savings” vs “costs” of the interventions include a broad definition of savings. As many of the savings made by possible interventions will be accrued outside of the NHS e.g. in Social Care, we feel that it is important that this is specifically mentioned as part of the scope and a thorough approach taken to identifying these.	Noted, thank you. The health economic analyses will consider a number of perspectives including, but not limited to, the NHS.

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General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		We note that the original referral from the Department of Health specified "disadvantaged areas". Whilst we agree that this guidance must be especially relevant in relation to supporting people from Spearhead areas in receiving early diagnosis and subsequent lifestyle modification we are unsure as to whether you are proposing to only be considering interventions and issuing guidance in relation to Spearhead LA areas. Would you please provide clarification. We are aware that many of the interventions will be applicable to small areas and the guidance may need to be specifically targeted and tailored to the specific needs of local communities in wards, GP practice catchments areas, super output area or even individuals. In our view, the issue of the scale at which an intervention may work may also enable the guidance to have wider application to areas of deprivation outside of Spearheads.	The scope will include evidence on interventions in disadvantaged areas and all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of the interventions identified in the scope (statins and/or smoking cessation services). Thank you ,noted.
General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		Would you consider including a definition of "pro-active case finding"?	Proactive case finding involves approaches which are aimed at identifying people at risk of a decline in health status. In some instances these people may already been known to the health care services because they already have medical needs, in other instances such people may not be in regular contact with health care professionals. The search strategy will seek to identify specific examples of these approaches with particular reference to smoking cessation and statins.
General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		We feel that the process of "testing" the final guidance will be essential in relation to ensuring the guidance is workable in the communities that are often suffering from multiple deprivation and low aspirations especially in terms of health. We would welcome further information on your plans on how this will be undertaken.	Thank you, agreed. The final draft guidance will be tested using a variety of research methods. The primary focus of the research will be to examine the relevance, utility and implementability of the guidance with its key audiences.

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General	*Department of Health* ** The comments submitted by the Department of Health were received and incorporated from the DCLG, DFeS, HMT, DH Obesity Team, DH SATs, DH CMHU & CultureDCMS*		You may wish to review and update the background data you have used in the report in light of the recently produced *2006 Update of headline indicators* *http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI* *And also the Health Profile of England (DH, 2006)* http://www.dh.gov.uk/assetRoot/04/13/95/22/04139522.pdf	Thank you for this suggestion.
General	*East of England Public Health Group*		The scope is narrow compared to the DH remit set in Appendix A of the Draft Scope. Focussing on health services only, it is not clear whether and how sectors other than the NHS will be involved in reducing inequalities in mortality rates. The new commissioning framework for health and wellbeing puts responsibilities on PCTs and LAs and LAAs as a delivery mechanism. As such recommendations should include LAs as in the recent obesity guidance	Thank you for your comment. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS.
General	*East of England Public Health Group*		By how much is the gap in inequalities likely to be reduced by targeting only health services? It is likely that the most significant contribution to reducing inequalities will be in improving economic, social conditions, physical environment and education	Thank you for your comments. Unfortunately tackling the broader determinants of health falls outside the remit of this scope and the development of intervention guidance. NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

General	*East of England Public Health Group*		The medical model puts the focus downstream and on primary and secondary prevention such as pharmaceutical interventions (e.g. Statin, BP) but does not address social marketing and compliance with long term drug treatment, nor the wider lifestyle and behavioural change issues linked to active lifestyles/smoking/ 5-a day etc	Thank you for your comment. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. In this context the outcome measures are concerned with service provision including access, recruitment, uptake and retention rather than the effectiveness of the intervention per se. Should the evidence include information on social marketing and compliance these issues will be considered.
General	*East of England Public Health Group*		It is important not only to identify interventions that have the greatest impact on reducing premature mortality and on increasing access to these services, rather also examine interventions that increase use of services particularly for those who had already failed to use a service they were considered to need	Noted. Thank you for your comment. As indicated above the focus of the scope is on service provision including access, recruitment, uptake and retention with specific reference to the smoking cessation services and prescription/use of statins.

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General	*East of England Public Health Group*		We suggest NICE guidance to address: • Delivery issues such as how to increase ownership, community involvement, specific management and leadership required for implementations of the guidance • Setting priority between different interventions • Capacity issues- the increase in demand of services and additional resources required to implement the interventions • Ways of reporting outcome to demonstrate any health benefit achieved. For example, if the outcome of both disadvantaged and less disadvantaged groups improves (e.g. through shifting of resources) the inequality gap per se may remain unchanged despite the health improvement.	Thank you for your comments and suggestions..
General	*East of England Public Health Group*		It is important that NICE guidance recommends how to evaluate the impact of such interventions on reducing the number of premature deaths and inequality in health	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.

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General	*Family Planning Association (FPA)*		FPA is concerned that the scope for the public health intervention guidance on tackling health inequalities is too narrow. By focusing solely on adults at higher than average risk of premature death from heart disease, stroke or cancer, NICE is missing an opportunity to have a wide-ranging impact on broader health inequalities.	Thank you for your comments which are noted and agreed. Unfortunately tackling the broader determinants of health falls outside the remit of this scope. NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality. As a result of this consultation and discussions with the Public Health Intervention Advisory Committee the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*Family Planning Association (FPA)*		FPA would have liked the scope of the guidance to include sexual health inequalities. Evidence from the Teenage Pregnancy Unit has shown that rates of under 18 conceptions are far higher amongst deprived communities (see *Teenage Pregnancy: Accelerating the Strategy to 2010*, Department for Education and Skills, 2006). The National Chlamydia Screening Programme has found that positivity has been higher amongst people from certain ethnic minority backgrounds, for example it was higher in people from black British and black Caribbean backgrounds (14%), and lower in those from the Asian subcontinent (4.8%) (see *New Frontiers, Annual Report of the National Chlamydia Screening Programme in England 2005/06*, Health Protection Agency, 2006). Access to high quality sexual health services are vital for everybody to help to reduce the impact of sexually transmitted infections and unintended pregnancies. In addition, interventions such as high quality sex and relationships education can lead to young people delaying sexual activity and makes them more likely to use contraception when they do decide to have sex.	Thank you for your comment. Unfortunately this falls outside the remit of the scope. However, NICE has recently published guidance on preventing sexually transmitted infections and under 18 conceptions which can be accessed by visiting: http://guidance.nice.org.uk/PHI3 You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*Family Planning Association (FPA)*		The National Strategy for Sexual Health and HIV, published by the Department of Health in England in 2001, included an aim to reduce inequalities in sexual health. Despite progress being made with implementation of the Strategy, inequalities and inequities in service provision still exist. Therefore it would be helpful for NICE to consider and develop guidance on interventions that would further support the implementation of the Strategy and the reduction of sexual health inequalities.	Thank you for your comment. Unfortunately this falls outside the remit of this scope. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*Heatlhcare Commission*		We welcome your focus on this area of work, which will result in guidance for colleagues working in services in disadvantaged areas. We particularly welcome the broad approach that your speakers indicated that you are taking to this work, which will include the broader policy environment and the impact that has had on the widening health inequalities as well as particular interventions to tackle the situation. There are a small number of issues we would like to highlight. We would ask you to clarify what is meant by 'services' in this instance and ask you to consider how few services are being delivered by the NHS in isolation, and that increasingly they are delivered in close partnership with local authorities and others. This will affect the kind of evidence you seek to generate and the focus of your guidance. Whilst it is obvious that the target is beneficial to driving work forward in this area, there remain concerns about the problems in the way in which the life expectancy target impacts on delivery: the large size of the areas within the target acts as a deterrent in tackling health inequalities between smaller areas within both spearhead and all other areas; achievement of those areas outside the spearhead areas is also counter to the target set and this therefore minimises the drive to improve in those areas. Guidance might also consider how best to support colleagues working in area–based initiatives who wish to extend benefits to individuals and families who have discernible health needs living in the same borough, but unable to access privileges of New Deal for Communities programmes, for example. Whilst at this stage of the target implementation there will be clearly and understandably no change to it, it would be helpful to flag up these issues and suggest ways in which the problems can be over-come. We look forward to continuing our collaboration with NICE and wish to restate our commitment to collaborate. At the meeting, I said that we are happy to share data we have, in particular the findings from our Tobacco Control Improvement Review, which assessed all PCTs in England. It concluded that those areas engaged in HAZ and Spearhead initiatives (which had resulted in an increased focus on the issue together with a greater share of funding for tobacco control), were performing better. We hope this data will contribute to your review and to supporting improvements for those communities carrying the burden of disease.	Thank you for your support and comments. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS. As a result of this consultation and discussions with the Public Health Intervention Advisory Committee the scope has been amended to include areas outside spearheads, disadvantaged or vulnerable adults wherever they live as well as disadvantaged areas. With the specific focus on smoking cessation services and prescription/use of statins it would be helpful if you could provide NICE with the data you have that informed your Tobacco Control Improvement Review.

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General	*Imperial College London*		Why ignore all previous evidence that reducing health inequalities involves more than the health services on their own? Surely your advice to local authorities and PCTs should emphasise: (1) inter-sectoral alliances at the local level; (2) lobbying upwards for effective inter-departmental initiatives at central government level?	Thank you for your comments. Unfortunately tackling the broader determinants of health falls outside the remit of this scope. NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*Imperial College London*		Why concentrate on cancer, heart disease and stroke – other causes of death and disease may offer quicker returns (eg. accidents; addictions)?	The achievement of PSA targets and the local authority summary of the index of multiple deprivation are directly linked to a reduction in these diseases. Also, given resource and time constraints, NICE has had to narrow its focus You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home.

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General	*Imperial College London*		Why concentrate on behavioural change when the evidence suggests it is ineffective as a means of reducing health inequalities?	Thank you for you comments. The focus of this scope is on proactive case finding, retention and access to services and, as a result this consultation and discussions within the Public Health Intervention Advisory Committee, will be limited to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services NICE will also recommend that future guidance be developed on reducing infant mortality as well as separate guidance on population based approaches to reducing health inequalities.
General	*Imperial College London*		Why not recommend interventions that have been shown to work, such as physical exercise for sedentary (near-chair bound) elders – strengthens muscles and increases joint flexibility so that the inevitable falls result in broken collar bones rather than fractured necks of femur?	Thank you for your comment. Unfortunately this falls outside the remit of the scope. The focus of this work is service delivery including access, recruitment, uptake and retention rather than the effectiveness of the intervention per se. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home.

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General	*Imperial College London*		Why not recommend interventions for which there is pent-up demand, such as alcohol detoxification and drug rehabilitation facilities?	Thank you for your comment. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*Institute of Health & Society, Newcastle University*		General, 1 & 2 (A), 4.4.1- The referral is problematic because it focuses only on disadvantaged areas. Inequality is patterned according to gradients of socio-economic position and other social factors, so that not all the disadvantaged people live in the disadvantaged areas. Assuming that you can't change the referral, It will be important to ensure that the evidence gathered and recommendations made are applicable to disadvantaged population groups wherever they live, so that this evidence guidance can contribute to reducing inequalities across the board.	Thank you for your comments which are noted and agreed. The scope has been amended so that it includes evidence about vulnerable or disadvantaged adults wherever they live as well as disadvantaged areas. .
General	*Institute of Health & Society, Newcastle University*		The recommendations will need to be considered very carefully. I suspect there will be a tendency to look for and report complex interventions that may have an impact on inequality. However, the simple things may be very important (in particular, if you accept that inequality might be affected at every stage of the intervention process (see White et al, mentioned above). Things you might consider include: ethnic and socio-economic monitoring, monitoring of inequalities in delivery, access, uptake, compliance, efficacy of interventions etc.).	Thank you for your comments. The focus of the scope includes a number of the measures of you have suggested such as proactive case finding, retention and access to services. Moreover, as a result of this consultation and discussions with the Public Health Intervention Advisory Committee the scope has been narrowed to consider these issues in relation to the smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services

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Gerneral	*LB Newham*		LB Newham welcomes the draft guidance and the opportunity to comment on it. We are keen to understand better "what works" in terms of reducing premature deaths and welcome the focus of this guidance.	Thank you – your support is welcomed.
General	*Lewisham PCT*		There is not sufficient emphasis on the impact of partnership working with the local authorities- although it is clear that the NSF health promoting targets should be key elements of the health inequalities plans. The NSF pathways should be more clearly gap reducing and targeted but it is not clear how this would be operationalised. I am still not clear whether the scope in the document is solely on the reduction to the 2010 floor targets. If so, this would seem like a sensible option given the timescales and therefore my comments for feedback are: -Broadly ok and sensible scope - need to focus more on the 2010 targets - needs clear focus on the NSF pathways - needs more focus on access and engagement - needs some guidance on whether 'within' borough gaps- or gap to National (re targeted wards) are priority - needs some discussion on other pct issues/context that can have adverse impact on the gap (particularly for London pcts) - there needs to be some acknowledgement on how the factors interact- e.g social determinants causing prolonged stress (physical and mental) on particular groups and result is premature death, therefore which is the critical pathway to tackle within a given timescale for a public health intervention to be effective?	Thank you for your comments. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services NICE will also recommend that future guidance be developed on reducing infant mortality as well as separate guidance on population based approaches to reducing health inequalities.
General	*Margaret Stanton*		Grateful for clarification regarding the above guidance topic (see attached earlier email). The remit referred to NICE by DH Ministers included reference to "other sectors" whereas the scope currently being consulted on only refers to guidance for the NHS. I understand this issue was raised at the meeting you held with stakeholder organisations on 8 Feb but am unclear what the outcome has been. Grateful if you could clarify the position.	Thank you for your comment. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS.

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General	*MRC Social & Public Health Sciences Unit*		Compared with the draft scope for the NICE work I'm involved in (physical activity and the environment), this seems quite well defined. My main concern is about the potential mismatch between the objectives stated in the title (1) and the referral from the DH (Appendix A) and the outcomes listed (4.5). The title reflects the emphasis in the referral on reducing the [premature] mortality rate in disadvantaged areas, but the only outcomes mentioned in 4.5 relate to 'service reach'. It's therefore not entirely clear how the key questions listed in 4.6 are to be framed or turned into operable questions for the systematic reviewers or the committee: they are all expressed in terms of How effective are these interventions..?', but effective in what terms? Identifying needs? (4.5) Increasing accessibility? (4.5) Increasing uptake? (4.5) Reducing mortality? (1) What about the other intermediate outcomes: changes in behaviour (e.g. smoking or physical activity); changes in blood pressure, lipids and other risk factors; changes in hospital admission rates..?	Thank you for your comments. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. In this context the outcome measures are concerned with service provision including access, recruitment, uptake and retention rather than the effectiveness of the intervention per se.
General	*MRC Social & Public Health Sciences Unit*		Focus on heart disease, stroke and cancer is arguably too restrictive. Deaths from these causes are already falling, though less quickly in deprived than in affluent areas. Alastair Leyland's work on trends in mortality using Census data shows that deaths from alcohol-related diseases and suicide are rising sharply and contributing to widening inequalities in mortality between derived and affluent areas. Another obvious point is that there are a number of relevant examples of area-based interventions in Scotland, including Healthy Respect, Have a Heart Paisley, Choose Life and Keep Well/Prevention 2010 - though they haven't yet contributed much in the way of evidence of effectiveness.	Thank you for your comments and examples. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins.

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General	*National Childbirth Trust*		The draft scope has a disappointingly narrow focus, looking only at adults suffering from heart disease, stroke and cancer, therefore excluding child, maternal and perinatal mortality which have significant impacts on life expectancy. Children and women from disadvantaged and lower socio-economic groups are known to suffer significantly higher levels of adverse child and maternal health outcomes, contributing to increased likelihood of child or maternal mortality. Exclusion of these factors from the guideline therefore significantly reduces the potential impact that the guideline could have on reducing rates of premature death in disadvantaged areas. We would recommend that the scope be widened to include looking at infant mortality (and different rates between socio-economic and ethnic groups) and also how factors during pregnancy (such as nutrition and maternal smoking) and early childhood (such as breastfeeding) play an important part in determining outcomes such as health status and life expectancy.	Thank you for your comments. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services NICE will also recommend that future guidance be developed on reducing infant mortality as well as separate guidance on population based approaches to reducing health inequalities. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*National Childbirth Trust*		Young mothers, those of lower socio-economic status or who left full-time education at an early age are least likely either to start breastfeeding or to continue breastfeeding for as long as other women. For example, 89% of women in managerial & professional occupations started breastfeeding compared to 67% of women in routine occupations. Younger and poorer women were even less likely to continue to breastfeed, exacerbating the differences.[i] These low breastfeeding rates may be one of the factors linking social adversity, disadvantage and health inequalities. For example, reviews show consistently that formula-fed babies are disadvantaged in health terms compared with babies who are breastfed. [ii] Rates of necrotising enterocolitis, and therefore mortality are higher in premature babies who are not breastfed.	Thank you for your comments, unfortunately this falls outside the remit of this scope. However, as indicated above, NICE will recommend that future guidance be developed on reducing infant mortality. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*National Childbirth Trust*		Maternal mortality is known to be higher in women who are economically and socially disadvantaged, including women living in extreme poverty, those facing multiple problems, women from some minority ethnic groups and those who did not speak English, homeless or travelling women, refugees and asylum seekers. There are also those with stigmatising conditions such as previous mental illness, being under age or HIV positive, those who misused drugs, alcohol or other substances and those who experienced domestic violence.[iii] Although maternal mortality is low in proportion to the numbers who die from cancer or heart disease, these factors are likely to be similar and efforts to improve access to services should be relevant across the age range. Breastfeeding has an impact on breast[iv] and ovarian[v] cancer in mothers and on Type II diabetes.[vi] For each additional year of lactation, women with a birth in the prior 15 years had a decrease in the risk of diabetes of 15% (95% confidence interval, 1%-27%) among NHS participants and of 14% (95% confidence interval, 7%-21%) among NHS II participants, controlling for current body mass index and other relevant risk factors for type 2 diabetes. The high prevalence of diabetes, with its multiple complications, and breast cancer in particular, mean that these factors have a significant impact on premature female mortality.	Thank you for your comments, unfortunately this falls outside the remit of this scope. However, as indicated above, NICE will recommend that future guidance be developed on reducing infant mortality. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*NHS Health Scotland*		General 1 The focus of the project has shifted from 'Strategies for reducing health inequalities in the short, medium and longer terms' (as previously shown on the NICE website) to 'Proactive case finding and retention and improving access to services in disadvantaged areas'. This narrowing of scope is understandable, especially for Public Health Intervention (as distinct from Programme) Guidance, and the specific focus is an important one towards enabling healthcare and other services to play the part in improving population health and reducing health inequalities, as part of a bigger picture that includes 'upstream' action on determinants of good health and ill-health. Nevertheless, there is a pressing need for 'processed' evidence relating to the rest of the above bigger picture, and it would be helpful to have Public Health Programme Guidance on that, subject to a scoping exercise to ascertain whether there would be sufficient evidence for systematic review. At the same time, it is desirable to promote attention in public health research strategies to primary evaluations relating to the full bigger picture.	Thank you for your comments, which are noted and agreed. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also all vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services NICE will also recommend that future guidance be developed on population based approaches to reducing health inequalities as well as separate guidance for reducing infant mortality. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*NHS Health Scotland*		General 2 The NICE website indicates that the product will be 'Guidance for the NHS and other sectors on what works in driving down population mortality rates in disadvantaged areas where risk of early death is higher than average'. The draft scope on the other hand states that the product will be 'Guidance for the NHS on interventions that reduce the rates of premature death in disadvantaged areas: proactive case finding and retention and improving access to services'. Even accepting the narrowing of scope to proactive case finding/retention/improving access to services, it would be desirable to include relevant services outwith the NHS (particularly local authority services).	Thank you for your comments. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.
General	*NHS Health Scotland*		General 3 The draft scope refers to breaking down the populations in disadvantaged areas into various sub-groups. It would be helpful to look for evidence relating to the full range of equality and diversity strands (age, gender, ethnicity, religion and belief, disability, and sexual orientation), and not just among those who live in disadvantaged areas as defined.	Noted Thank you for your comments. As indicated above, the scope will consider vulnerable or disadvantaged adults wherever they live as well as disadvantaged areas.
General	*Royal College of General Practitioners (RCGP)*		We welcome this guideline as it will focus activity in an important and neglected area	Thank you.

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General	*Royal College of General Practitioners (RCGP)*		The draft consultation conveys the intention to inform PCTs on how they may commission services to address the inverse care law, but it does so without any obvious understanding of the problem to be addressed, and comes across as well intentioned but superficial.	Thank you for your comment. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services.
General	*Royal College of General Practitioners (RCGP)*		If the inverse care law were as simple a matter as could be addressed by rolling out some new interventions, it would have been sorted a long time ago. A major factor underlying the continued existence of the inverse care law is not the lack of interventions that work, but failure to deliver interventions that are known to work. The flat distribution of medical and associated manpower in general practice, irrespective of health need, makes it difficult for general pactices serving depirved areas to deliver sustained high quality care for the patients who need it most. Such practices need resources, not guidance - although how to invest resources in resource-starved services (with a depressed culture of care) is another issue.	Thank you for your comments. In the context of this scope, the term intervention refers to issues relating to service provision including access, recruitment, uptake and retention rather than the effectiveness of an intervention per se. The investment and reallocation of resources will be important considerations in this piece of work.

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General	*Royal College of General Practitioners (RCGP)*		The draft consultation mentions new ways of making contact with hard to reach groups. This is important, but following initial engagement and ascertainment, the challenge is to provide effective care, revering risks and preventing complications, based on long term relationships between patients and professionals whom they know and trust. New methods of engaging with hard to reach groups, must either link in with existing arrangements for long term preventive care, or provide alternative arrangements that are as effective. Applying a consumerist model of health care use, based on middle class people with busy lives, will not necessarily work in depirved areas. The call for evidence will be constrained, partly by the dearth of research carried out in these areas (raising questions about research capacityand priorities), but also by the high prevalence in deprived areas of people with mutliple, complex problems, whose needs do not neatly fit into National Service Frameworks, and whose co-morbidity is an exclusion criterion for most research, especially RCTs. In these several ways, the NHS is not set up to deal with, or examine the problems of people with complex problems. The consultation would be particularly useful if it not only collated the meagre research evidence that is available, but also flagged the sorts of questions that need to be researched, with appropriate prioritisation and investment in research capacity.	Thanks for your comments. We agree that there are a number of issues that could potentially have an impact on inequalities – existing practice and new methods of engagement are duly noted. NICE will draw on a broad range of evidence relating to proactive case finding, retention and access to services. Gaps in the evidence and important research questions that remain unanswered will be reported in the final guidance document.
General	*Royal College of Nursing*		The RCN welcomes the proposals for this public health intervention. We are aware that there has been some early diagnosis and prevention work done for cancer in some of the Spearhead PCTs.	Thank you. It would be helpful if you could submit or direct NICE towards your sources of this information.

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General	*Royal College of Paediatrics and Child Health*		We are aware that the NICE website has changed the title of the guidance now out for scoping from 'Strategies for reducing health inequalities' to 'Proactive case finding and retention and improving access to services in disadvantaged areas' and is looking only at adults. We believe that the guidance should address the interventions and service initiatives needed to promote equity in child health (especially as the Acheson report says the evidence we have suggests it is most cost effective to target interventions at the levels of maternal and child health) and not to focus the inequalities agenda on services for adults with an increased risk of early death only. There is a pressing need to improve services to disadvantaged children and young people, and we feel that this deserves attention. We would be disappointed if NICE chose only to look at adults. Not only is there ample evidence of massively higher stillbirth, neonatal death and infant mortality rate in SC5 compared to SC1 - see below, but also clear evidence that once you are socially disadvantaged you are more likely than not to stay that way. Need to fight the fire as it breaks out not when it is rampantly established [Infant mortality rate (IMR) is a key measure of a society's effectiveness in caring for children. It is an accepted indicator for measuring a nation's health status and social well-being. The UK has a relatively high IMR in relation to our wealth and there are marked differences between the most and least economically and socially disadvantaged. Although IMRs have fallen for all socioeconomic groups, the difference between the lowest and highest socio-economic groups has widened. For example, in 1994-6, there were 3.3 more infant deaths per 1,000 live births in the lowest socio-economic group than in the highest. In 2001-3 the difference was 4.5. The Latest Figs for the difference between least and most deprived quintiles for SB rate = 10.4 and neonatal death rate = 6.5.]	Thank you for your comments. As a result of this consultation, and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. Unfortunately tackling infant mortality falls outside the remit of this scope so NICE will recommend that future guidance be developed on this subject. NICE will also recommend that separate guidance be developed for population based approaches to reducing health inequalities. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*Sandwell PCT*		The focus is on NHS interventions, however it is well acknowledged that health inequalities can only be addressed through tackling wider determinants of health – role of partner interventions e.g. housing, poverty, education, transport etc.	Noted. Thank you for your comments. Unfortunately tackling the broader determinants of health falls outside the remit of this scope. NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*Sandwell PCT*		The focus appears to be very clinical, focusing on disease areas such as CHD, stroke, cancer – this makes it increasingly difficult for public health practitioners to engage with clinicians (e.g. GPs) in delivering health improvement interventions (e.g. welfare rights advice delivered in primary care setting, or interventions to address fuel poverty)	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will consider evidence about interventions in disadvantaged areas, and also vulnerable or disadvantaged adults (wherever they live), so long as they are users or potential users of these services. Unfortunately tackling the broader determinants of health falls outside the remit of this scope. NICE will therefore recommend that future guidance be developed on population based approaches to reducing health inequalities. NICE will also recommend that separate guidance be developed for reducing infant mortality.
General	*Sandwell PCT*		The focus is on what PCTs should be doing. From our perspective we, as a Joint Health and Social Care Policy Unit deliver interventions in partnership with Adult and Community Theme	Thank you for your comment. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS.

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General	*Sandwell PCT*		Target audience is aimed at professionals working in the NHS, however we feel the target audience should be broader e.g. local authority, considering the emphasis by the Department of Health on joint working and the proactive role local authorities in tackling inequalities, we expected to see a link between that emphasis and the scope of the guidance.	Thank you for your comment. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS.
General	*Sheffield PCT*		As indicated at the event, this is scoping interventions that may be part of a wider programme. It is important to look for and monitor any negative consequences as well as positive impact of interventions, particularly on inequity. Many interventions may be intended for the worst 20% but taken up in greater numbers by those outside the intended group. I believe that we all in public health support the view of justice in health that says that in order to address inequity in health we need to treat people unequally. This is difficult within the NHS culture of providing universal services. In Sheffield we introduced the CIRC programme (Citywide initiative for Reducing Cardio vascular disease) targeting service improvement for secondary prevention at deprived communities. This was very successful and nationally quoted. However there was also a view that in the context of the NSF the work should be applied across the city to all practices. Whether this will reverse some or any of the successful reduction in narrowing the gap in mortality rates will only emerge in time as there is a time lag between intervention and effect.	Thank you for your comments. We agree that it is important to identify the negative consequences for health inequalities that might arise from activities. NICE recognises the importance of the broader determinants of health inequalities and will recommend that future guidance be developed on population based approaches to reducing health inequalities. You can also suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home It would be helpful if you could provide NICE with any literature/you have on the CIRC programme.

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General	*Sheffield PCT*		The CIRC programme was developed, commissioned and evaluated as part of Sheffield's HAZ programme. There is I am sure a considerable body of evidence that was generated within the 26 HAZs across the country, that focuses on improving access to services in disadvantaged areas. This may not have reached the literature but will have been documented to meet the performance management demands of the DoH. Many HAZs will now be spearheads and therefore some "corporate" memory may remain but other such as Sheffield may not. The level of investment and variety of approaches within the HAZ programme I believe was unprecedented and it would be a shame if the evidence generated around work on inequalities was not utilised to inform future effort.	Thank you for your comment. The guidance will draw on a broad range of literature relating to these activities, particularly around smoking cessation services and prescription of statins. Whilst we plan to contact relevant agencies it would be helpful if you could provide us with any relevant literature and advise us of other contacts you have who may have collected this information.
General	*Sheffield PCT*		I am encouraged that the evaluation approach adopted within the HAZ programme of what works for whom and in what circumstance features throughout the scoping document. The role of local context is vital to the success and failure of many "effective" interventions. What works in one community may not be transferable to another. It is important in the absence of gold standard evidence that this is not an excuse for inactivity. Consideration should also be given to the plausibility of an intervention. One of the key elements to achieving this goal of reducing inequalities at any level is being pinpoint clear as to what success looks like. This enables comparative measurement. This avoids people using "hard to reach" and "disadvantaged communities" as catch all terms and enables scrutiny of whether the intervention identified offers a plausible solution to achieving a reduction in premature death within the target population.	Thank you for your comments. As a result of this consultation , and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. The population groups and interventions will be specified according to these interventions as will the outcome (or success) measures.
General	*Newham PCT*		One of the most important disincentives to reducing health inequalities is allowing GPs to exempt patients in the calculation of their achievement for points. Very often it is the most vulnerable/difficult/hard to reach patients who are exempted. Some practices exempt up to 30% of pateints with disease in order to achieve their points. This clearly has the effect of incentivising an increase in health inequalities. In order to reduce this disincentive it should be nationally agreed that patients cannot be exempted for anything other that clear and precisely defined clinical reasons	Thank you for your comment. It would be helpful if you could submit or direct NICE towards your sources of information.

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General	*Southwark PCT*		This issue is too important to be left to the DH. All other public services and public servants need to take more responsibility of the health, and well-being of the population, and fostering resilience in populations through appropriately designed and delivered services. I would suggest that the compilers of the scoping review take account of the recommendations of Health Impacts: a strategy across government. (Council for Science and Technology). http://www2.cst.gov.uk/cst/reports/files/personal-information/csthealthimpacts.pdf ▪ This report came at a time when NICE has ceased to support the HIA Gateway originally set up by the HDA. This appears a highly retrograde step, and it is hard to see how improvements in population health can occur if Health Impact Assessment is ignored in favour of purely economic/environment assessment. Action at local level would benefit greatly from focussed health impact assessments where there is a real health gain to be made as well as promoting better partnership working. Clear guidance to PCTs as to how they should work with local authorities to ensure that health issues are dealt with in their plans and policies would be welcome in this area. Should the HIA gateway be relocated to the Dept. of Communities and Local Government and be developed with the needs of a non-health audience to inculcate greater public health literacy?	Thank you for your comment and the reference. As a result of this consultation and discussions within the Public Health Intervention Advisory Committee, the scope will be amended to focus on proactive case finding, retention and access to services with specific reference to smoking cessation services and prescription / use of statins. It will draw on evidence from published and grey literature on a broad range of activities around pro-active case finding and retention some of which may involve health impact assessments. Unfortunately some of your suggestions fall outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*Southwark PCT*		As the recent update from the DH on Tackling Health Inequalities (Dec 2006) states: 'There is considerable variation within the Spearhead authorities. Life expectancy in some Spearheads is increasing faster than the average and if their trends were replicated in all Spearhead areas, the life expectancy targets would be more than me'. Is work being done to understand why this is happening? This is part of the evidence but high quality research will be necessary to identify what activities are responsible for this (as opposed to other secular trends not influence by PCT activity) and make recommendations regarding their applicability in other spearhead areas.	Thank you for your comments. Unfortunately this falls outside the remit of the scope. However, you can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home
General	*Surrey PCT*		Welcome the development of the guidance	Thank you.

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General	*Surrey PCT*		We all have areas of disadvantage with inequalities gaps, not only the spearhead areas	Thank you for your comment. The scope will be amended to reflect factors relating to individual and social deprivation as well as those relating to area deprivation.
General	*UK Public Health Association*		The topic is welcomed by the UKPHA since combating health inequalities is one of our three core missions. *The UKPHA consulted its entire membership in putting together this response. The comments below therefore include those made by individual members and, as a whole, reflect the overall balance of opinion of all those responses we received.* *For ease of identifying the key issues that our members have raised we have categorised the response into a series of independent headings*	Thank you for your efforts and contributions.

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General	*UK Public Health Association*		The UKPHA has difficulty accepting that the Guidance is indeed aimed at public health interventions. By the very nature of the groups identified we are dealing with *NHS* interventions aimed at reducing the impacts of conditions and diseases which have their genesis in the wider social, economic and environmental circumstances in which populations live their lives. We are therefore, it seems, still dealing with public health issues in the context of a national sickness service which deals in downstream end-of-pipe solutions which pay no heed to the origins of the detriment suffered. There has been a plethora of guidance and advice about how to reduce inequalities. Most of this has focused on reduction of individual risk factors. Despite sterling attempts to target individuals and to reduce risk factors, inequalities have continued to widen. The UKPHA suggests that NICE needs to recognise that spending yet more money in this way is not necessarily a cost effective use of resources The document is too clinically oriented, as demonstrated by the fact that only NHS professionals are considered target audiences. The key to effective public health working is in the title of the scope of this paper, proactive and improving access, however it is set in a medical context of case finding, rather than Choosing Health through community networks. The UKPHA contends that social, economic and environmental factors are the main determinants of health inequalities. Poor housing, poor nutrition, low educational standards and feelings of low self esteem reinforce conduct which is destructive to personal health. In the wider society the great disparities in wealth and the over-emphasis on competitive individualism do not encourage social integration.	Thank you for your comments. Unfortunately tackling the broader determinants of health inequalities falls outside the remit for this scope and the development of intervention guidance which by its nature has a narrow focus. However, NICE will recommend that future guidance be developed on population based approaches to tackling health inequalities. The issues of cost-effectiveness, allocation of resources and opportunity costs will be considered in the development of this guidance. As a result of this consultation and discussions with members of the Public Health Intervention Advisory Committee the focus on service provision will be with specific reference to smoking cessation services and prescription/use of statins. You may be interested in NICE guidance currently in development on community engagement (http://guidance.nice.org.uk/page.aspx?o=CommunityEngagement) and behaviour change (http://guidance.nice.org.uk/page.aspx?o=BehaviourChangeMain) which deal with some of the issues you raise. NICE recognises and appreciates that there are a number of different organisations that have a remit for tackling inequalities. We will

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General	*UK Public Health Association*		Background and the need for Guidance A key requirement is to demonstrate the impact of interventions on vulnerable groups and in the most deprived geographical areas. The information given to comment on gives the impression that the fast moving NHS and public health policy agenda will overtake the guidance. The other concern from experience of putting public health NICE guidance already published into practice is that we should encourage critique and consideration of the contribution that grey evidence makes to best practice that Wanless identified as important in today's public health practice. .As the scoping document focuses on the actions that PCT's should take to reduce health inequalities, the ethos of the guidance needs to take partnership working as its starting point and set the context in "fully engaged" rather than interventions. The intervention centred approach may lead to isolated work programmes implemented from the top downwards that we know do not make a difference to reducing health inequalities. The agenda for NICE guidance, if it remains aimed at PCT's, should carry a strong message that the evidence for effective interventions is not necessarily NHS led. A different approach is indicated in seeking to improve the health of the population in deprived areas. The reduction of *mortality* from cancer and CVD is a recurrent theme. It would be a much better investment, instead, to try and reduce the *incidence* of these diseases, something which can be effectively achieved with primary prevention strategies. In fact, primordial prevention would be even more effective and cost-saving on the long term, but this would require strong political actions from a wide range of stakeholders beyond the NHS. We wish to draw attention to the absence of timescale to the measurement of outcome to "service reach". (Para 4.5 - Itself a loaded term). Whereas the short-term NHS focused programmes addressing proximal determinants may (or may not) demonstrate short term impact, this will only be sustained if it is underpinned by the more structural changes addressing the distal determinants, (which is more likely to come from the partnership working with local authorities and neighbourhood based bodies and organisations, as the current draft rightly observes).	Noted. Thank you for your comments. The literature searches will all be carried out by our collaborating centre at the University of Cardiff, in collaboration with information colleagues at NICE. We are considering different approaches to identifying relevant literature and will include grey literature. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS. With the revised focus on smoking cessation services and prescription/use of statins the scope places a greater emphasis on primary prevention. The timescale over which outcomes are measured will be determined by the evidence we find. Nevertheless, the issue of sustainability will be an important consideration in the development of this guidance. You can suggest a topic for NICE to develop guidance on by visiting: www.nice.org.uk/page.aspx?o=ts.home

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General	*UK Public Health Association*		<u>Local Authorities as key players</u> Local Authorities have experience in working with and seeking the views of local communities e.g. Children and Young People. Mental Health has experience in working with their speciality. Do PCT's have any particular experience in working with the hard to reach populations? It is usually the more articulate who voice their needs where health is concerned. NICE should particularly acknowledge the duties for Well-being placed on Local Authorities, the strengthened leadership role for LAs within LAAs for better health and well-being outcomes and the emphasis government is placing on Joint Public Health, Joint Commissioning and Joint Assessment Frameworks.	Thank you for your comments. We agree and the scope will be amended to include other agencies.

General	*UK Public Health Association*		<u>Partnerships</u> It is surprising that NICE does not recognise the importance of local partnerships. Many PCTs across the country have already established some very effective links with local councils and other organisations, precisely because they have realized that there are interventions which require more than a strictly medical approach. It is vital to consider health inequalities as a WHOLE, i.e. in the context of social determinants. whether as practitioners or policy makers in the NHS. In that respect NHS needs to acknowledge and be vigorous in its place in this:- by means of partnerships with other organisations Partnerships are crucial to addressing health inequalities. Partners (e.g. education, housing, voluntary orgs, elected members, etc) are very enthusiastic about public health, but frequently complain 'health' (i.e. local NHS) is either absent, or not represented at sufficiently senior level for effective decision-making. Similarly health professionals and local authority staff alike need to explore and develop new and creative ways of working in partnership with communities. Labonte argues that '...community development offers the best means by which health authorities might contribute to remedying underlying health determinants. A potential hazard is a narrowing of the field to that of the secondary prevention of CHD and stroke through interventions in primary care, reflecting the current emphasis on ways of achieving the 2010 targets. It is obviously important to review this area as well as to encourage implementation of what is already known to work. However, other important areas such as partnership working across local authorities and the voluntary sector, or through joint strategies for achieving targets in local area agreements and a longer term approach to reducing health inequalities are also key and while the NHS is not always in the implementation seat, there remains the leadership role as well as joint public health appointments across the NHS and local authority. PCTs should reinforce the cross-cutting nature of interventions i.e. services work together & with other partners such as local authorities, businesses and community organisations to provide the agreed elements in a strategic plan and not in isolation.	Thank you for your comments. We agree and the scope will be amended to be inclusive of partnerships.

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General	*UK Public Health Association*		Community Development There is no recognition of the relationship between the lived environment and how this affects communities. There is an ambiguity between sections 4.3.1 and 4.3.2. 4.3.1 suggests that community development initiatives will be covered while 4.3.2 (a) states that interventions and activities not aimed at reducing and/or eliminating premature death will not be covered. This assertion seems to misunderstand the nature of community development which has been described by the Community Development Foundation as "to help groups and networks of people to take joint action on matters that concern them for the public good. Effective joint action is built on forming group relationships, and often needs to engage with agencies that deliver public services. The work usually has a local focus, through communities of interest such as faith groups as well as local communities ." As the most successful initiatives are often dependent upon the enthusiasm, vision and sense of ownership of those involved and many initiatives are short-term funded and agency-led, we contend that there is a 'layer' missing in the evaluation/evidence base and that as a result the evidence base of 'what works' is flawed. The Guidance should enable a comparison to be made between the outcomes of those initiatives implemented/delivered 'top down' and those developed 'bottom up': Imposing or delivering an initiative that has proved effective in one 'community' (in helping to meet the government's commitment to reducing the HI gap/ PCTs in delivering on specific outcomes) in another 'community' perceived as similar . Initiatives that have begun with the 'community' identifying • How they see the problem • What intrinsic and extrinsic gains will there be for them in any engagement – e.g. 1.	Thank you for your comments. You may be interested in NICE guidance currently in development on community engagement (http://guidance.nice.org.uk/page.aspx?o=CommunityEngagement) which deals with some of the issues you raise.

			A new resource for the community (that they really want) if x% people in the community give up smoking • Save money • Feel better and live longer and which have then developed solutions a. based upon what those who are part of the 'community', know about what works or doesn't work in the 'community' b. b. that are informed by evidence of what similar initiatives have worked in other areas c. c. are therefore community specific and have built in long term sustainability by increasing individual and 'community' empowerment and capital	
General	*UK Public Health Association*		This would: a. Support a differentiation between the evidence from different approaches b. Provide a more robust understanding of what works, why and when etc including a clearer understanding of the relative role and importance of government, agencies, professionals and 'community' in achieving health improvement c. enable guidelines of good practice to be developed as a key to policy making and professional practice. Given the DH request, the focus on NHS interventions is disappointing, where partnership initiatives would seem more appropriate. It is good that community development initiatives are mentioned, but worrying that there is no attempt to put more detailed 'meat' on this particularly set of bones, given the importance of communities in determining their own health expectations.	Thank you for your comments. See earlier comments regarding the revised scope and the inclusion of other agencies and partners that have a role to play in tackling health inequalities.

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General	*UK Public Health Association*		<u>NHS-based public health interventions</u> The UKPHA, along with all of its members, welcomes any intervention which will help address inequalities of access to services and obtaining information on healthy lifestyles. The NHS has a crucial role to play in such an endeavour, but clearly without addressing the wider determinants of public health, the title of the Scope is misleading. On behalf of our members we would like to offer the following comments with respect to NHS-based interventions. Given that the referral from DH asked for 'guidance for the NHS and other sectors on what works' the scoping document is disappointing in its focus on the NHS. It is important that those who work in the NHS (a) fully appreciate the massive impact on population health of non NHS interventions, and (b) appreciate the responsibility they have in achieving real partnership with other sectors where the consequences of poor health are not so acutely felt. The NICE approach is appropriate from a disease specific perspective - and in that sense will contribute to equity from a health service perspective. We should take care not to underestimate the importance that this will have for individuals.	Thank you for your comments. We recognise and appreciate that there are a number of different organisations that have a remit for tackling inequalities. We will amend the scope to ensure that it includes other organisations outside the NHS. We also recognise the complex nature of underlying determinants of health inequalities and will recommend that future guidance be developed on population based approaches to reducing health inequalities. We will also recommend that future guidance be developed on reducing infant mortality.

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General	*UK Public Health Association*		<u>NHS-based public health interventions</u> We face two challenges in addressing health inequalities -focussing on the underlying determinants AND ensuring that people have access to the basic health services that they are entitled to. This scope addresses the latter. The key issue is a semantic one. The proposed scope is not public health guidance - it is NHS inequalities guidance (and its title should reflect this) which is an area that has had inadequate attention for too long. The UKPHA welcomes the inequality focus within the scope which will at long last start to bring an inequality element to mainstream NHS activity that has been absent. The guidance will allow local authorities to scrutinise the NHS more effectively - in particular ensuring that they focus resources and good quality services towards those who most need them. The production of this scope highlights a considerable deficit in NICE guidance generally most of which is does not recognise that inequalities impacts on clinical practice at all. It is an indictment of NICE that local organisations PCTs, Primary Care etc. increasingly seek to sensitise all aspects of their service to inequalities issues and yet when reading NICE guidelines it appears that inequalities does not exist at all! The scope needs to recognise that one of the challenges faced by some NHS services is not just meeting the needs of disadvantaged communities but of working with communities in transition and flux - migrants, refugees, asylum seekers, travellers etc. This presents particular challenges with regard to engagement, ongoing treatment etc. While including walk in centres etc is OK the focus of the scope must be on mainstream provision - GPs - the guidance should help us define what good looks like in primary care - so as to inform commissioning and contractual relationships with GPs. Finally - timescale - as always seems to be the case with NICE guidance its production is downstream of the issue - we are focussing on this work now - if this guidance comes out in 18 months time the chances are that it will just confirm standards, not drive improvement.	Intervention guidance necessarily has a narrow focus. However, NICE recognises the complex nature of the underlying determinants of health inequalities and will recommend that future guidance be developed on population based approaches to reducing health inequalities. We will also recommend that future guidance be developed on reducing infant mortality.

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General	*PHIAC*		Consider the implications for the health economics work, in particular QALY's, of defining interventions interventions in terms of 'process' rather than 'treatments'	Noted. Thank you for your comment
General	*PHIAC*		A need to include organisations working in Partnership with the NHS rather than imply it with the words NHS-led	Thank you for your comment, the scope will be amended accordingly.