Public Health Intervention Guidance

Identifying and supporting people most at risk of dying prematurely–Consultation on Draft Guidance– Stakeholder Response Table 23rd April – 22nd May 2008

Stakeholder Organisation	Evidence submitted	Section	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Association of Public Health Observatories		General		Why is Hypertension excluded? Some of the limited evidence base includes work on hypertension in black and minority ethnic groups. It would make sense to include hypertension, especially as work on hypertension is to be included in the recently announced vascular prevention programme.	Thank you. The inclusion of hypertension is beyond the remit of this particular guidance.
Association of Public Health Observatories		General		The guidance refers to NHS and 'Others' in quite a loose way, however, 'Others' will not be prescribing statins. It might be better to be cleared how the different parts of the system are expected to work together.	Thank you for your comment which has been considered in the redrafting of the guidance.
Association of Public Health Observatories		General		The focus of the document is on reducing inequalities between the worst and the average and links to the Government targets for reducing inequalities between the spearhead group and the average. However, it is possible that this context will change, and inequalities are broader than this. In addition there is already a mix of Government targets e.g. the smoking target aims for a reduction in the smoking prevalence in the routine and manual groups. In addition, LAAs will have a different definition, but it would be useful to link them in to this guidance.	Thank you, the final guidance has been amended accordingly. It also makes reference to both the policy context and broader determinants of health inequalities.
Association of Public Health Observatories		Definitions	5	There doesn't appear to be a definition of 'proactive case finding' in the document, but it would make sense to include one. The document implies that the proactive finding of cases should be undertaken by organisations outside as well as inside the NHS. This should be included in the definition.	Thank you. This has been clarified in the final version.
Association of Public Health Observatories		Definitions	5	The definitions section contains a long list of individuals who are disadvantaged, but it should be made clear that this list is not exhaustive and that the case finding should not rule out individuals that are disadvantaged for reasons other than those listed.	Thank you, this has been amended accordingly.

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Association of Public Health Observatories		Definitions	6	The definition of disadvantaged areas relates to the DH definition of spearhead areas. I am not sure that this can be generally applied. In addition, there is an error in this definition. The fourth component is cardiovascular disease mortality rate in under 75s not prevalence.	Thank you, the definition of disadvantaged areas has now been changed
Association of Public Health Observatories		Recommendation 1: Finding clients	7	Should the target population be people who are disadvantaged who smoke or are at high risk of CVD due to other factors or who are eligible for statins? At the moment it reads as if they have to be disadvantaged and meet all of the other criteria. This comment also applies to Recommendations 2 to 5.	Thank you for your comment. This has now been amended accordingly.
Association of Public Health Observatories		Public health need and practice	15	The statement 'Since 1995-97, circulatory diseases have become more prevalent, in relative terms, among these groups' is not referenced and it is not clear which groups are being referred to. The rest of this paragraph seems to refer to information from the 2007 Status Report on the Programme for Action, but this document is not included in the reference list. The statement about 44 per 100,000 people is not strictly true as this figure is taken from the difference between two standardised rates. It would be safer, in this section, to quote information directly from the Status Report and reference it accordingly.	Thank you for your comment. The text has been amended and the reference for the statement is located at the end of the paragraph (DH, 2008a)
Association of Public Health Observatories		Considerations, section 3.3	18	A reference is make to 'lack of resources' in this section. However, the NHS is currently underspent. I might be better to refer to stretched LA resources or the fact that the PCT resource allocation is currently under review. A point could also be made about redirection of effort and resource to where it is most needed.	Thank you for your comment. Your point is well made but this guidance is also aimed at organisations outside of the NHS. Nevertheless the text has been amended and emphasises the importance of EFFECTIVE deployment of resources.
Association of Public Health Observatories		Considerations 3.10	19	QOF data – this is important to refer to, but it is important to state that people who get listed as exclusions under QOF (i.e. excluded from the population eligible) are likely to be the people that should be	Thank you for your comment,exception reporting is covered in Recommendation 3 of the final guidance.

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				targeted for case finding.	
Action on Smoking and Health		General (& point 3.8)		Smoking accounts for half the difference in life expectancy between the highest and lowest socio-economic groups and it is therefore important that measures to tackle smoking form a major component of any plan to reduce deaths from cardiovascular disease. ASH therefore welcomes this draft guidance. However, whilst we accept that both smoking cessation interventions and the use of statins are cost effective, it is not clear from the draft guidance how decisions about implementing these two interventions would be made. Clearly, where appropriate, both smoking cessation treatment and statins should be offered. However, both health professionals and patients need to understand that quitting smoking has demonstrable health benefits with no adverse outcomes whilst statins can have side effects. Furthermore the evidence on increased life expectancy after quitting smoking is robust while that for statins is equivocal. Cont'd	Thank you for your comments. Much of the implementation of this guidance is the responsibility of local commissioners and/or providers and should be done in light of their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties. Thank you for your comment. In generating the guidance. NICE has given consideration to the issues you have raised.
Action on Smoking and Health		General (& point 3.8)		Smoking cessation is also likely to be more cost effective than the prescription of statins. As the evidence on page 52 demonstrates, interventions to help smokers stop smoking are very cost-effective and for those who successfully quit smoking there is likely to be a substantial improvement in both the quality of life and expected lifespan. For statins, however, the cost appears to be greater than that for smoking cessation (when the full cost of statins is taken into account) and although the risk of premature mortality from CVD may be reduced in some population groups, there are not the same overall health gains that can be achieved by stopping smoking. In some cases, quitting smoking will be enough to reduce CVD risk	Thank you for your comments. Evidence of cost-effectiveness was demonstrated for both smoking cessation and statins.

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				without the need to prescribe statins. Therefore we recommend that this is reflected in the guidance.	
Asthma UK		General		As the voice of people with asthma, Asthma UK welcomes the opportunity to respond to this consultation. Asthma UK is the charity dedicated to improving the health and well-being of the 5.2 million people in the UK whose lives are affected by asthma. Smoking significantly effects the health of people with asthma and currently 28% of people with asthma smoke. This is of considerable concern given that smoking is a major trigger for peoples' asthma. We welcome and support measures designed to increase and improve access to smoking cessation services in deprived areas where smoking prevalence is often higher than average and access to and quality of health services can be poor. However, we are disappointed that respiratory disease, including asthma, is not included in the target populations within the draft guidance as respiratory disease is the second biggest killer in the UK (British Thoracic Society – Burden of Lung Disease 2nd edition 2006).	Thank you and we welcome your contribution. Due to time and resource restrictions NICE has only been able to cover CVD in this piece of guidance. There is a facility on the NICE website (www.nice.org.uk) to suggest future topics for consideration.
Asthma UK		Health inequalities		Asthma UK is committed to tackling health inequalities and as smoking behaviour is strongly related to a person's socio-economic class we believe that improving smoking cessation services is key to improving health outcomes. Data from Asthma UK's National Asthma Panel 2008 shows that 34% of people with asthma from the lowest socio-economic group smoked compared to 21% of people from the highest socio-economic group. According to *NICE – Smoking Cessation Services (Quick Reference Guide February 2008)* smoking cessation rates are lower among people in routine and manual groups compared with those in	Thank you for your comments, references and additional evidence. Many of your points are covered in the guidance.

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				higher socio-economic groups. We support measures designed to increase and improve the quality and access of smoking cessation services in deprived areas. We agree that national and local initiatives must be developed and sustained on a long-term basis. Strategies must be devised collaboratively and included in PCT plans and local area agreements with input from local community and voluntary groups who may have greater access to and a better understanding of local needs. Smoking cessation services should be part of a package of improved services for people with asthma. We hope these issues are addressed in the Government's forthcoming Green Paper on Health Inequalities. Stronger commitments are required from the Government and mandatory measures must be introduced forcing PCTs to specifically target deprived areas.	
Asthma UK				We would also like more detailed proposals on how healthcare professionals and commissioners are going to access and engage with individuals or communities in deprived areas particularly when there are likely to be language and cultural barriers. Specific training will be required in an attempt to overcome these problems.	Thank you. The implementation issues you raise are addressed in this guidance, further detail is beyond the remit of this piece of guidance. Implementation of this guidance is the responsibility of local commissioners and/or providers and should be done in light of their local context. I would also refer you to other recently published 'Community Engagement NICE guidance' (www.nice.org.uk) which may address some of the issues you raise
Asthma UK		Improving services		We believe that tailoring services to reflect the needs of different communities is crucial. We support the recommendations on improving accessibility on pages nine and ten, for example devising services that are flexible and reflective of cultural and community needs. Many individuals from Black and Minority Ethnic (BME)	Thank you for your observations and comments. The guidance includes recommendations with actions for improving retention – see in particular Recommendation 2 of the final guidance.

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				groups or lower socio-economic backgrounds have little understanding of the health system, may be unaware of the smoking cessation services on offer and may be reluctant to use them. However while improving services is important we also agree that health outcomes will only be improved if people actually comply with and complete their course of treatment. Appropriate support mechanisms must exist and they must be tailored to suit the cultural needs of different communities. We also want the Government to ring-fence more money for NHS smoking cessation services to specifically target deprived areas and communities where smoking prevalence is high.	
Asthma UK		Health promotion and health literacy		Increasing health promotion is crucial because if some groups remain unaware of the services on offer then they simply won't use them. Health literacy can also be more pronounced in BME groups due to socio-economic and educational factors as well as for some language barriers. In order to reach BME groups and increase awareness of local services, health promotion interventions must be culturally sensitive and tailored to suit different languages and cultural styles in order to maximise use, for example perhaps by using more pictorial guidance. Regarding smoking cessation services, we believe that increasing education and awareness through a variety of public health campaigns and interventions must be a key priority for the Government particularly in deprived areas where awareness of the dangers of smoking is often low and uptake is high.	Thank you for your observations and comments
Barton and Tredworth Community Trust,		Introduction – 3rd paragraph	One	I really think the inclusion of "*It may also be of interest to members of the public"* is a very inclusive approach as it really does make the guidelines global.	Thank you.
Barton and Tredworth		Recommendation One, and	Seven	I note from the previous criteria of disadvantaged people (page 5) people on a low income, lone parents and low-income families,	Thank you for your comment.. The definition of disadvantaged people

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Community Trust,		other recommendations too.		people on benefits and living in public housing. – what I cannot see is any identification in any of the recommendations of the inclusion of social landlords. I look around locally and very few local authorities have not sold off, where they can, housing stocks to Social Landlords	includes people living in public or social housing. Whilst not explicitly mentioned in the recommendations social landlords would be [implicitly] included under 'organisations with a remit for tackling health inequalities' or 'members of the voluntary and business sectors' if they had a role in delivering the recommendations
Barton and Tredworth Community Trust,		Recommendation 1: finding clients	Eight	I note that you have identified" using community health workers (including health trainers) and outreach activities." to identify clients but may be we need to be more specific and identify it as people in their communities and neighbourhoods, why can't we identify shop keepers and small businesses?.	Thank you for your comment. The guidance has been amended where appropriate.
Barton and Tredworth Community Trust,		*Recommendation 2: improving services and retaining people*	Nine	Throughout this section I did not get a feeling that we were moving too much outside of funding non professionals in the community, training/retraining professionals in order to connect to a wide range of disadvantaged communities, for example older, disabled, faith, sexual orientated . In short, I do recognise we have a number of citations on ethnicity but we also have other strands which are equally disadvantaged. Also; are we highlighting the need to look at how smoking cessation and statin services are working at being mainstreamed for disadvantaged communities.	Thank you for your comment. The guidance has been amended accordingly. The considerations' section highlights the importance of mainstreaming activities that focus on disadvantaged communities,
Barton and Tredworth Community Trust,		*Recommendation 3: system incentives, under sub section,* What action should they take?	Eleven	I noted the sentence, "*ensure the projects are evaluated and, if effective, ensure they continue."* I think we need to go further and add roll out to other geographical areas where appropriate. My thought behind this is that when a project is good, i.e. in a pilot is acknowledged that should be extended to a wider geographical area wherever possible too	Thank you for your comment. The considerations' section highlights the importance of mainstreaming activities that focus on disadvantaged communities,

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Barton and Tredworth Community Trust,		*Recommendation 5: partnership working*	Thirteen	I note we use the term *"Establish links between practices and the community to identify how best to…."* - I know it may seem a use of words but I sincerely believe it is must be much more than establishing links, I would suggest we should be looking to using the word "relationships."	Thank you for your comments. The guidance has been amended accordingly.
Barton and Tredworth Community Trust,		*Recommendation 6: training and capacity*	Fourteen	I note that the term hard to reach is used in the first section "Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities" I would suggest that we look at altering this term as I do not feel that people/communities are hard to reach, rather the people/communities are seldom heard. Using the term hard to reach may suggest that it is the people/communities that are hard to reach, as opposed to the traditional systems in place/adopted to engage and involve people/communities.	Thank you for your comment. Your point is well made although the text to which you refer is the title of a guidance document published earlier this year. The importance of involving disadvantaged communities in the development of services is included in the recommendations.
Barton and Tredworth Community Trust,		Overall on the literature		Have we considered citing "A Dialogue of Equals – D of H (2008). This is a piece of work that is specific to working with seldom heard communities.	Thank you for this suggestion.
Barton and Tredworth Community Trust,		Terminology and population communities		I wondered if we had considered work around the traveller communities and people from emerging communities. I understand there is now the term BoME (Black and other Minority Ethnic) people	Thank you for this suggestion. In developing the recommendations the Public Health Independent Advisory body have considered evidence from the published literature, primary research on

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					current practice as well as expert testimony.
Bradford and Airedale Teaching PCT		Frontsheet	1	Given lack of evidence underpinning much of this – the fact that there will be NICE Guidance will be read by many as a licence to establish screening. Very careful cross reference to NSC policies in this area and very careful differentiation of screening and case finding.	Thank you for your comment, the considerations' section cross references related programmes such as the work of the UK National Screening Committee and the Department of Health's vascular checks programme.
Bradford and Airedale Teaching PCT		Introduction – recommendations (smoking cessation & provision of statins)	1	Whey just smok cess and statins? – given there is plenty of RCT evidence re, for example, diabetes prevention/interim lifestyle support (the Finnish and American DM Prevention Trials)	Thank you for your comment. These two areas were selected because methods of identifying and supporting adults and improving their access to services needed to be assessed using interventions which have already been established as effective and cost effective. Smoking cessation services and the provision of statins are both generally agreed to be effective and cost effective. The epidemiological data show a clear socio economic gradient for smoking and CVD, and tackling smoking and providing statins, as recommended, should make a significant contribution to reducing inequalities. The guidance document now includes text outlining this.
Bradford and Airedale Teaching PCT		Definitions	6	Might be helpful to have an explicit mention of the rationale for spearhead status here	Thank you for your comment, the text has been amended.
Bradford and Airedale Teaching PCT		Smoking Cessation and Statins	6	There is good RCT evidence for intensive lifestyle modification focused on multiple risk factors. Is this being ignored?	Thank you for your comment. Due to time and resource restriction this guidance focuses on strategies for finding and supporting those most at risk of premature death from CVD and other smoking related diseases by drawing on evidence from statins and smoking cessation.

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Bradford and Airedale Teaching PCT		Rec 1 – Finding Clients Rec 3 – System incentives	7 10	The most obvious place to look for high risk clients is those on existing QOF registers (esp COPD / CHD / DM / Heart Failiure etc) AND patients receiving OPD care for conditions worsened by smoking (and other lifestyle risks) AND patients post MI / Stroke / COPD admission etc etc etc	Thank you for your comments. Using QOF registers to identify high risk groups is one of the actions listed under Recommendation 1 of the final guidance.
				This guidance really needs to hammer that there are well documented inequalities in prevalence (diagnosed and within QOF and undiagnosed) and health care utilisation (primary and secondary care) – and that targeted interventions at key points in a care pathway - and that interventions to encourage a healthier lifestyle and encourage approp statin use in high risk patients / key life events is probably more effective and almost certainly more cost effective than a population wide approach.	Thank you for your comments. Many of these points are addressed in either the recommendations or the considerations' section.
				This leads to consideration of whether the levers and incentives (QOF payments and Tarrif) are appropriate to encourage an appropriately high focus on smoking cess / startng statin therapy for high risk patients (and ensuring the intervention is intensive enough to achieve change – given that the most disadvantaged might be the hardest to change group.	Thank you, levers and incentives are covered primarily in Recommendation 3 of the final guidance.
Bradford and Airedale Teaching PCT		Tackling Health Inequalities – Infrastructure & resources	7	Do we need to be explicit and acknowledge that "accessible" also includes a notion of appropriate and culturally appropriate	Thank you for your comment. The guidance highlights these points.
Bradford and Airedale Teaching PCT		What action – communities	8	Need to explicitly notion the role of community development in building community capacity and organisation capacity/competing to be responsive to the needs of vulnerably communities This doesn't ring out enough in this section……	Thank you for your comment. The guidance makes reference to the recently published Community engagement guidance which covers the aspects you

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					mention. This is available on the NICE website (www.nice.org.uk).
Bradford and Airedale Teaching PCT		Recommendation 2: Improving services and retaining people	9	Might need to differentiate screening and case finding!! See comments on front sheet. SCREENING AND CASE FINDING ARE NOT THE SAME THING – but in many people's minds they are synonymous. Could this guidance be taken as a mandate for establishing 'screening for smoking'? What would NSC have to say on this.	Thank you for your comments. Recommendation 1 focuses on actions for identifying people who are disadvantaged and at high risk of CVD. The considerations' section cross references related programmes such as the work of the UK National Screening Committee and the Department of Health's vascular checks programme.
Bradford and Airedale Teaching PCT		Health Equity Audits	10	Whether services are reaching people is one thing that can be assessed by H Eq A …… but H Eq A also needs to provide evidence that that **services are making a difference to outcomes** this should be highlighted	Thank you for your comment. The guidance has been amended accordingly.
Bradford and Airedale Teaching PCT		Recommendation 3 – system incentives	10	Give more thought to what incentives that are best applied through local areas/what national . Also tightening the rules on exception coding will have positive equality impact – giving additional levers and tools to PCTs to monitor and benchmark exception coding; and the mechanisms (through market development and contracting) to do something about persistent (and clinically unjustifiable) rates of exception coding would be helpful.	Thank you for your comments. The guidance has been amended accordingly.
Bradford and Airedale Teaching PCT		Who should take action?	11	Policy makers, planners and commissioners of WHAT – presumably health care services. This needs to be clarified. One such incentive would be to raise the upper threshold for QOF payment to 95-100% – perhaps supported by an additional payment, a bonus payment for achievement and a 'mid point' payment threshold (with less points attached to it). Positive incentivisation to encourage equality.	Thank you for your comments and suggestions. Further clarification on who should take action and what action they should take has been provided in the final version of the guidance. Recommendation 3 in particular focuses on incentives for services and activities aimed at the health of people who are disadvantaged. The considerations' section also highlights the importance of mainstreaming such services.

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				To be equitable through **needs** to be national approach to this	
Bradford and Airedale Teaching PCT		Recommendation 5 – Partnership working What action should they take?	12	All of this section seems a bit wishy washy. Could be made more explicit. What of cross referencing to other NICE Guidance on broader social policy in this area – supportive environments in which the healthy choice is easier. Urban planning / built environment springs immediately to mind – environments that encourage physical activity. Also (although no NICE guidance in this area) broader macro economic approaches to fiscal policy – food / tobacco / alcohol pricing etc etc. All of this supports those at most risk to adopt healthier lifestyles and thus reduce avoidable deaths.	Thank you for your comments. The guidance has been amended accordingly and makes reference to other relevant NICE guidance.
Bradford and Airedale Teaching PCT		Establish links between practices & the community	13	Practices should be doing this anyway!!!	Thank you for your comment. The evidence reviews and mapping review revealed substantial variations in current practice.
Bradford and Airedale Teaching PCT		Recommendation 6: What action should they take?	13	What about clinical skill & risk assessment & manage CV risk who is / should be doing this. Some cross referencing to the NSC Handbook – CVD Risk Assessment – would be helpful here.	Thank you for your comments. The guidance cross references the work of the UK National Screening Committee and the Department of Health's vascular checks programme and also includes references to related NICE guidance.
Bradford and Airedale Teaching PCT		Recommendation 6: Ensure practitioners hve the skills	14	NICE Weight management guidance should be cross referenced.	Thank you for your comment.. As this guidance focuses on smoking cessation and statins it cross references related NICE guidance on these specific topics as well as generic guidance on behaviour change and community engagement.
Bradford and Airedale Teaching PCT		5. Recommendations for research	21	What is the role of local government in presenting NICE – not hugely pertinent in context of this guidance – or it focuses on role of NHS in case finding – but context of Health Promotion is broader - social and economic environment. Reference to the and drivers for individuals to make healthy choices, which are set by local and national government.	Thank you for your comment.. This guidance focuses on strategies for finding and supporting those most at risk of early death and improving their access to services.

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British Heart Foundation		General		The BHF warmly welcomes this guidance and particularly its focus on smoking cessation services and the provision of statins. We have some concerns that the title of the guidance is unclear and inconsistent (various documents seem to have different titles). This could impact on its uptake by the target audience.	Thank you for your comment. The guidance and titles of reviews that inform the guidance have been amended accordingly.
British Heart Foundation		1 Recommendation 1: finding clients	Page 8	While we acknowledge that this guidance had been developed prior to the development of the DH's Vascular Checks, it seems prudent to mention the role that primary care professionals and those working in communities will have in implementing vascular checks. At the very least, it should be noted that the recommendations included in this guidance should be used to help implement the Vascular Checks.	Thank you for your comment. The guidance cross references the work of the UK National Screening Committee and the Department of Health's vascular checks programme.
British Heart Foundation		1 Recommendation 2: improving services and retaining people	Page 9 - 10	As well as ensuring that services are sensitive to cultural and gender issues, services should be age- appropriate as well.	Thank you for your comments. The guidance has been amended accordingly.
British Heart Foundation		1 Recommendation 2: improving services and retaining people	Page 9 - 10	While we note and support the final recommendation on page 10 – seek feedback from the target populations on whether services are accessible, appropriate and meeting their needs – the BHF is surprised that there is no recommendation underlining the importance of also involving the target population in the design and, where possible, the delivery of services.	Thank you for your comment. The guidance has been amended accordingly
British Heart Foundation		1 Recommendation 2: improving services and retaining people	Page 9 - 10	The use of motivational interviewing and respecting patients ideas, concerns and expectations should be explicitly mentioned. Motivational interviewing enables informed choice and is likely to improve engagement with the intervention.	Thank you for your comments. Recommendation 2 includes an action to involve people who are disadvantaged in the planning and development of services. It also recommends feedback be sought from the target groups on whether the services are accessible, appropriate and meeting their needs.
British Heart Foundation		1 Recommendati	Page 11	As you note in section 3.8 on page 19, "generally, however, targeting people who are disadvantaged is more costly than targeting the	Thank you for your suggestions.

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		on 3: system incentives		general populations." Policy makers, planners and commissioners must ensure that "incentives for targeting people who are disadvantaged" will more than compensate service providers for the inevitable higher costs of developing local projects to reach disadvantaged groups. While some level of incentive may be appropriate for simply targeting people who are disadvantaged (perhaps cost recovery), significant bonus payments should be reserved for reaching and engaging people who are disadvantaged, not just targeting them.	
British Heart Foundation		1 Recommendation 6 – training and capacity	Page 13	Service providers and practitioners are important targets for training but so are lay people – particularly in the context of reaching disadvantaged groups. The BHF recommends including lay-people as recipients of training.	Thank you for your comments. The guidance has been amended accordingly
British Heart Foundation		1 Further Recommendation?	Page 13	The BHF would like to see the recommendations for research alluded to in section 5 (page 21) and outlined in appendix D, incorporated into the main recommendation section.	Thank you for your suggestion which we pass on to the relevant team at NICE.
British Heart Foundation		3.11	Page 19	While the BHF accepts that activities aimed at reaching disadvantaged groups should be part of mainstream services wherever possible, we also believe that there is a need for bespoke services that are designed with and for disadvantaged groups – what your guidance seems to disparagingly refer to as "cottage industries." Both approached – making mainstream services more appropriate and developing bespoke programmes – are necessary. We suggest that "Cottage industries" is too emotive a term and should not be part of the guidance.	Thank you for your comment. The guidance has been amended accordingly.
The British Psychological Society		General		The focus on smoking cessation and statins in deprived groups is welcomed since the desired change in either could have a profound effect on health in at risk individuals. The six recommendations are sensible and directed at the pertinent issues. We agree capacity building, (No 6) is particularly important since all the other efforts will fail if the system lacks capacity or fails to access the capacity that exists.	Thank you.

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The British Psychological Society		General		Smoking cessation is a behavioural change problem and we know that there is difficulty in providing enough behaviour change specialists in many areas of behaviour modification. Fortunately Health Psychology courses now produce a substantial number of Masters level graduates with many of the core skills and they should be recruited for reducing health inequalities.	Thank you. Readers are referred to a number of national organisations including the British Psychological Society for further information on training.
The British Psychological Society		General		We do not think that the prescription of statins raises the complex behaviour problems of smoking cessation. However, we understand that adherence to statins is not good in routine clinical practice, simple programmes should be developed by behaviour change specialists to ease their use.	Thank you for your comment. The guidance cross references NICE guidance on behaviour change.
The British Psychological Society		General		The advice given in the recommendations is sound but it is clear that the evidence base for much of it is patchy. We do not really know the best way to reach these groups nor to move them onto a healthier path. We agree with that different approaches should be tried. We would suggest that different demonstration sites be set up using different models to enable the development of an effect model (or models) that is both powerful and also flexible enough to deal with local variations in conditions.	Thank you for your comment and suggestions. The guidance includes recommendations for research and highlights gaps in the evidence. Also highlighted in the considerations' section is the importance of evaluating and monitoring current practice and innovation.
Department of Health, Vascular Programme		General		The guidance needs to cross-refer to the Department's Vascular Checks Programme, currently in development. As there is quite a lot of work going on in this area it is especially important that the key players for implementation can see how they all dovetail without duplication. The document "Putting Prevention First" is the most recent published update. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083822 It also needs to look forward to the NICE's forthcoming Guidance on prevention of cardiovascular disease in different populations which is currently being scoped.	Thank you for your comments. The guidance cross references the work of the UK National Screening Committee, the Department of Health's vascular checks programme and related NICE guidance.
Department of Health, Vascular		Recommendation 1	7	The voluntary sector should be included in the list of people to take action. It would be helpful to make the point that high-class	Thank you for your comment.. Although not explicitly mentioned in the

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Programme				commissioning should enable local services to make the best use of their local voluntary sector, as well as providing those organisations with more stability than one- and three-year project grants have permitted.	recommendation, the voluntary sector is specifically mentioned in both the introduction to the guidance and the introduction to the recommendations. The types of organisations included in the who should take action section of recommendation 1 implicitly include the voluntary sector.
Department of Health, Vascular Programme		Recommendation 3	11	Key levers to reference would be the Joint Strategic Needs Assessment and World Class Commissioning	Thank you for your comment, these levers are included in the final version of the guidance.
Department of Health, Vascular Programme		Recommendation 4	12	Some examples would be helpful as this is potentially a controversial area	Thank you for your comment, individual incentives are not included in the final version of the guidance.
Department of Health, Vascular Programme		Recommendation 5	12	Again, Joint Strategic Needs Assessments, Local Area Agreements, the GP Contract and World Class Commissioning could helpfully be referenced	Thank you for your suggestions, these have been included in the final version of the guidance.

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Department of Health, Vascular Programme		Recommendation 6	14	Both commissioners of training and the Royal Colleges could be cited as key players in ensuring that training is delivered to the right staff and to the right standard	Thank you for your comment. Commissioners have been included within who should take action group.
Diabetes UK		1.	8	It would be useful to add engagement with third sector organisations to the list of methods to identify clients used by primary care professionals. In addition, organisations which work with client populations may also be well received in terms of cold calling methods.	Thank you for your comment.s and helpful suggestions. The approaches reommmended within the guidance document are based on the evidence available to the committee. All of the recommendations generated by NICE are based on the best available evidence. As such we cannot include elements within the guidance which were not part of the evidence base that was examined. The guidance is for NHS and other professionals who have a direct or indirect role in, and responsibility for, services aimed at people who are disadvantaged. This includes those working in local authorities and the wider public, voluntary and community sectors. It may also be of interest to members of the public.
Diabetes UK		1.	8	It would be better to describe the education sessions as “tailored” this would make this recommendation more inclusive of the needs of a diverse range of groups who could benefit from these sessions. The recommendation as it stands implies that it is focussed solely on ethnicity.	Thank you for your comment.. We have retained the wording that was used in the effectiveness reviews to describe these types of approaches.
Diabetes UK		1.	8	It would be useful to explicitly highlight the value of the awareness raising that the education sessions will create, and the benefits that may arise from further awareness raising spread to other family members and friends as a result.	Thank you for your comment
Diabetes UK		1.	8	It would be valuable to state explicitly the process for continuity of care once people at risk have been identified with regards to support and onward referral.	Thank you for your comment, this issue is implicit across the recommendations.
Diabetes UK		1.	9	Under what action should be taken :	Thank you for your comment. We have

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				The first bullet point needs to be broadened to incorporate the need for services that can be tailored to meet individual needs, abilities and views of health. For example to consider the needs of people with learning disabilities, multiple and cross cutting conditions, low literacy levels. This bullet point is related to the fourth bullet point which again needs to consider how services are able to tailor their support to individual needs, abilities and views of health beginning by understanding the perspectives, beliefs and experiences of the individual.	amended the 4th bullet point within recommendation 2 of the final guidance to reflect the need for the tailoring of services. The 2nd bullet point recommends involving people who are disadvantaged in the planning and development of services. It also recommends seeking feedback from the target groups on whether the services are accessible, appropriate and meeting their needs.

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Diabetes UK		1.	9	Under what action should be taken : When discussing support with transport under bullet point three it would be valuable to add the pertinence of this for people living in rural areas.	Thank you for your comment. Transport has only been provided as an example in this instance. Although we appreciate the need for help with transport for those in rural communities, we do not wish to suggest that those who are not from rural areas could not benefit from help with transportation.
Diabetes UK		1.	9	Under what action should be taken : Under bullet point 5 it would be valuable to spell out which populations these service structures would be helpful for, for example proactive outreach/ drop ins may be useful service structures for homeless people.	Thank you for your comment. However, we are not able to provide an exhaustive list that details which populations services may or may not be useful for as these may vary depending upon local needs. As such we have only highlighted that these structures could benefit those individuals who are disadvantaged.
Diabetes UK		1.	9	Under what action should be taken : Under bullet point 6 it would be valuable to include proactive consultation of different local populations to identify the best methods for providing proactive support. Local community groups and organisations could be used as well as focus group sessions.	Thank you for your comment. We have amended the guidance to suggest the involvement of people who are disadvantaged in the planning and development of services.
Diabetes UK		1.	11	Under “who should take action” it would be valuable to state that this spans health and social care.	Thank you for your comment. However we cannot produce an exhaustive list and therefore social care is implicitly encompassed within “other organisations with a remit for tackling health inequalities”
Diabetes UK		1.	11	There is a danger that using a system of incentives in this manner could encourage the tackling of health inequalities to be viewed as an “add on” rather than mainstreaming these approaches. It may be better to look at how recommendations can encourage changes in the system and how this can subsequently be rewarded. Ultimately what will be required are resources including time and capacity to	Thank you for your comments. The recommendations are based on the best available evidence. System incentives were one of the interventions that were highlighted as being effective in tackling health inequalities. The issue of

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				deliver services in a different manner, including the use of public health workers.	mainstreaming is highlighted in the considerations' section of the final guidance.

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Diabetes UK		1.	12	It would be helpful if the guidance gave examples of the kinds of incentives being considered.	Thank you for your comment. Whilst the guidance recommends the use of different types of systems' incentives the precise nature of these should be determined by local needs. Therefore we do not think it is appropriate to provide a pre-determined list.
Diabetes UK		1.	12	The level of effectiveness of incentives in bringing about long-term behaviour change, particularly for more complex behaviour change has been questioned. An examination of the literature identified issues of relapse/ lack of long term maintenance of healthier behaviours in some cases once incentives were removed.[1] 1. Jochelson (2007) "Paying the Patient" King's Fund	Thank you for your comment. However we are not able to accept additional evidence at this stage. Additional evidence can only be accepted during the evidence consultation process.
Diabetes UK		1.	12	Under what action should be taken : Bullet point 1 - the language of "community activists" is inconsistent with the terminology of the rest of the guidance and the term "activist" may create an unnecessary barrier to building partnerships.	Thank you for your comment. The guidance has been amended accordingly.
Diabetes UK		1.	13	It would be useful to include a bullet point on providing training and support to advocates and community workers in relation to health issues.	Thank you for your comment. Under the target population in recommendation 5 community and lay workers have been included.
Diabetes UK		1.	13	The first bullet point should include ensuring there are enough public health workers in relation to ensuring capacity.	Thank you for your comment. The guidance has been amended.
Diabetes UK		2	16	The Diabetes National Service Framework[1] Standard 1 specifically outlines the need for strategies to reduce the risk of developing Type 2 diabetes and reduce the inequalities in the risk of developing diabetes. The NSF identifies the increased risk of some disadvantaged groups in developing diabetes and the potential for risk to accumulate for individuals who belong to crosscutting/multiple groups experiencing disadvantage. This is important considering that diabetes is the second leading cause of CVD after smoking.[2] Furthermore people from South Asian and African Caribbean communities are at increased risk of developing CVD at a younger age. This means that strategies to identify those at increased risk	Thank you for your comment. However the tackling of diabetes itself is not within the remit of this guidance. This guidance draws on the evidence base relating to smoking cessation and statins to identify strategies for finding and supporting those most at risk of early death and improving their access to services.

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				need to consider these differences in age. **References:** 1. Department of Health (2001) Diabetes National Service Framework : Standards Crown Copyright 2. Diabetes UK (2007) Diabetes Heartache	
Diabetes UK		2	17	It is vital to consider the needs of people with diabetes within this guidance particularly as diabetes is the second leading cause of CVD after smoking in the UK. People with diabetes are at increased risk of developing CVD, women with diabetes have an 8 fold increased risk and men have a five fold increase in risk.[1] Whereas statins form part of the approach to helping protect against CVD, a multitude of other interventions and support also apply for people with diabetes. Individuals need to be considered holistically and interventions for people with diabetes will include lifestyle support and advice, potentially weight management, and management of biomedical factors including blood glucose control as well as blood pressure and lipid control. A significant proportion of diabetes management is self management. Structured education programmes for people with diabetes are a vital tool for supporting people with diabetes to self manage. NICE has recommended that structured patient education is made available to people with diabetes, and outcomes from structured education programme evaluations demonstrate improvements in biomedical outcomes such as blood glucose and blood pressure levels and body weight and waist circumference.[2] References 1.Diabetes UK (2007) Diabetes Heartache 2. http://www.diabetes.org.uk/Professionals/Shared_Practice/Care_Topics/Patient_education/	Thank you for your comment. However the tackling of diabetes itself is not within the remit of this guidance. This guidance focuses on smoking cessation and statins to identify strategies for finding and supporting those most at risk of early death and improving their access to services.
Health Care				1. I welcome this particular public health guidance and its potential	Thank you for your comment.

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Commission				contribution to tackling health inequalities.	
				2. It would help if the guidance were to draw out the action needed for different types of organisation.	Due to variation at the local level it is not possible within this guidance to produce a definitive list of organisations and actions for them to undertake.
				3. Separate out commissioners and providers - particularly in recommendation 6	Thank you for your comment
				4. It would help to separate out statins and smoking cessation re the action needed- it is often very different for these two areas of work.	Thank you for your comment
				5. The recommendation 3 - system incentive is set at the local system level and I feel there needs something pitched at national and regional level to provide incentives in the system that will drive down to local level. Something like "Regulation and performance management at national, regional and local level need to work together to ensure the levers are in place to improve the commissioning and delivery of smoking cessation (programmes and services) and statin prescribing."	Thank you for your comment. The section 'who should take action' is not restricted to the local level – it refers to policy makers, planners and commissioners. The list of actions provided within the recommendation is not meant to be specific and exhaustive. As such the recommendation can be applied at many different levels.
				6. The point you have - using relevant indicators and ensuring target-setting and exception reporting do not increase health inequalities sounds very negative. 7. How about turning it into 2 points - using relevant indicators to measure progress and compare with other areas and organisations. - ensuring target- setting tackles health inequalities whereever possible and that target setting and exception reporting does not increase health inequalities	Thank you for your comment. The guidance has been amended accordingly.
				8. There needs to be more reference to working in partnership to deliver the smoking cessation programmes and services and connecting that to Local Area Agreements.	Thank you for your comment the guidance has been amended accordingly.

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					The connection between partnership working and local area agreements has been now been made.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		General		We welcome this guidance in adopting an explicitly pro-active approach to tackling health inequalities among disadvantaged groups.	Thank you for your comment

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Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		General		We feel, however, that while the document is far-reaching and broad-ranging, it fails to address the specific difficulties of targeting individual groups. The solutions for the various disadvantaged groups will vary enormously and the currently available evidence base appears inadequate to provide any accurate estimates of cost effectiveness.	Thank you for your comment. We recognise the needs of specific groups may vary and the guidance recommends strategies for addressing these. The cost effectiveness analysis, which includes a review of the evidence, modelling reports and sensitivity analyses indicate that these approaches are cost-effective.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		General		There is little or no reference to education within the school setting both for parents and children. Poor educational attainment is common, especially among young male manual workers who leave school early. Poor literacy and numeracy may represent a barrier to health education via printed media	Thank you for your comment. The definition of adults who are disadvantaged does not exclude people with poor educational attainment – the list is not intended to be exhaustive. The guidance does, however, recommend that support and services be tailored to the needs of disadvantaged adults.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		General		Early prevention of risk acquisition should be a priority	Thank you for your comment.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		General		Why is smoking cessation limited to those 16 or over? Surely it would be beneficial at whatever age?	Thank you for your comment. However, due to time and resource constraints it was necessary to restrict the scope of the guidance. The age of 16 was chosen as this was the legal age of purchasing tobacco at the time the guidance was being produced.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		General		There is little mention of healthy diet and lifestyle which is a vital part of risk management and one which should be applied more widely than statin intervention.	Thank you for your comment. This guidance is concerned primarily with the systems that need to be in place to find and provide access to those most at risk. The specific nature of the interventions that should be provided are the subject of other NICE guidance which is cross

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					referenced in this guidance.

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Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		Recommendations Definitions	Page 5	Poor educational attainment especially in terms of literacy and numeracy should be included, perhaps defined by a suitable GCSE achievement threshold	Thank you for your comment. The characteristics included in the list of disadvantaged adults is not intended to be exhaustive. The guidance recommends that providers undertake their own needs assessments using tools which are appropriate. Moreover, we are not aware of a suitable educational achievement threshold that denotes an individual as disadvantaged.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		Recommendation 1	Page 8	Line 3 There should be a requirement to ensure that all target groups are registered with primary care	Thank you for your comment, this is covered in the 4th bullet point of Recommendation 1 in the final guidance.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		Recommendation 2	Page 9	Should consider the provision of information in video or web based format to overcome accessibility barriers inherent in printed media	Thank you for your comment. This example has been included in one of the bullet points. That said, the support detailed within the recommendation is not meant to be an exhaustive list. The specific interventions to be used should be determined at the local level according to local needs.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		Recommendation 3	Page 11	Consider provision of comparative performance data to encourage providers to meet targets	Thank you for your comment. The guidance has been amended accordingly
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		Recommendation 4	Page 11-12	We are surprised that the issue of prescription charges has received no mention. Research into the impact of this versus Scotland and Wales should be considered	Thank you for your comment. Recommendation 4 on individual incentives has been removed from the final set of recommendations.
Hyperlipidaemia Education &		Recommendation 5	Pages 12-13	This section neglects the role that secondary care has to play in the identification of patients at high risk of events already referred for	Thank you for your comment.. Action in secondary care has been included in

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Atherosclerosis Research Trust (H·E·A·R·T UK)				management of one of the principal cardiovascular risk factors - pharmacist based smoking cessation; nurse-led smoking cessation and lifestyle clinics; nutrition & dietetic strategies implemented initially in secondary care. This should include action in secondary care in general (oncology, respiratory medicine, surgery) as well as CVD related clinics.	Recommendation 4 of the final guidance.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		2. Public Health Need and Practice	Page 16	NHS organisations should note that they are employers of many workers in socially disadvantaged groups and they should be encouraged to make greater efforts on health promotion. If NHS employees do not exhibit healthful behaviours this will seriously undermine efforts to improve public health and reduce inequalities.	Thank you for your comment.
Hyperlipidaemia Education & Atherosclerosis Research Trust (H·E·A·R·T UK)		2. Public Health Need and Practice	Page 17	Regarding poor compliance with treatment, it has been recognized that engagement with knowledgeable health professionals who can explain the need for treatment and support of family who have accepted treatment are important factors in therapeutic compliance[1]. Access to well trained practice nurses, GPs and secondary care physicians is therefore important McGinnis, B., et al., *Factors Related to Adherence to Statin Therapy.* Ann Pharmacother, 2007. **41**(11): p. 1805-1811.	Thank you for your comment and reference. The importance of training is reflected in Recommendation 5 of the final guidance.
Institute of Health & Society, Newcastle University		General		It would be helpful to have a recommendation on measuring inequalities in smoking and blood lipids and on measuring inequalities in the outcomes of smoking cessation and statin prescribing interventions. Practitioners, policy makers and managers need explicit advice and recommendations to help ensure a consistent approach to measurement if they are to achieve the other recommendations in this useful guidance.	Thank you for your comment. The guidance recommends the use of health equity audits to determine if services are reaching people who are disadvantaged and whether they are effective
Mind		1	5	We welcome the inclusion of people with mental health problems as an identified group. Along with people with learning disabilities they are particularly at risk of early death from killer diseases. Smokers with mental health problems smoke more heavily and are more dependent on it than other smokers. We hope this guidance will help bring urgency and practical impetus to delivering smoking	Thank you for your comment. This guidance is concerned primarily with the systems that need to be in place to find and provide access to those most at risk. Readers are referred to related NICE guidance for information on the specific

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				cessation/reduction support and CVD screening/intervention to people with mental health problems.	nature of the interventions that should be offered.

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Mind		1	7	We would strongly agree with the statement of need for a broader strategy with sustained action. Following the Disability Rights Commission's Equal Treatment: Closing the Gap report (2006) on physical health inequalities experienced by people with learning difficulties and/or mental health problems, this must include full implementation of the Disability Equality Duty by primary care organisations.	Thank you for your comment
Mind		Recommendation 1	8	Cold-calling – we would query the effectiveness and/or acceptability of cold-calling by telephone for people with mental health problems	Thank you for your comment, the guidance has been amended. Although cold-calling is no longer included in the examples listed it could be used if considered appropriate.
Mind		Recommendation 1	8	Analysis of QOF data is a very important method. QOF includes a register of people with long-term mental health problems (who agree to be on it) and annual health checks for them. Guidance from NICE specifying that this should lead to any necessary health promotion advice and offers of relevant interventions would be very helpful. However this should not be relied upon to reach all people with mental health problems in a practice as not all will agree to be on the register and some practices will limit inclusion to those with diagnoses such as schizophrenia and bipolar disorder.	Thank you for your comment. The guidance includes recommendations on the use of QOF and the need for service providers wherever they are based to encourage everyone who is disadvantaged to register with a general practice.
Mind		Recommendation 1	8	The reference to 'long-stay psychiatric institutions' is a bit dated. It would be helpful to refer to mental health day services and community-based mental health services as well as residential and nursing home care and in-patient provision. (Or more generically to 'mental health services'. However it would not be helpful directly to target people using crisis/acute mental health services for support with stopping smoking as this would not be a good time to do it.	Thank you for your comment.
Mind		Recommendations 2, 5	9-10	Smoking reduction and cessation services should be provided in ways which are easily accessible to people who experience mental distress. Many people may find general smoking cessation support services do not meet their needs. A range of community based smoking cessation services, including those specifically targeted at	Thank you for your comment.s. Recommendation 2 in the final guidance is particularly relevant to the points you have raised.

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				mental health service users, should be made available by PCTs. Voluntary and community groups are well placed to run such services, if provided with resources to do so. Examples of specialist services are those run by Mind Aberystwyth, Wandsworth PCT and West Surrey Stop Smoking Service.	
Mind		Recommendation 2, 5	9-10	We would add a reference to sensitivity to the difficulties of quitting if people smoke as a form of self-medication (eg to alleviate symptoms of psychosis) and more generally to cope with distress or facilitate social interaction.	Thank you for your comment. The importance of taking into account individuals' needs is one of the actions covered in recommendation 2.
Mind		Recommendation 1 / 2		The metabolic side effects of antipsychotic/neuroleptic drugs are known to represent a serious risk to physical health. Active screening of people prescribed this medication is advocated by the Royal College of Psychiatrists. http://www.rcpsych.ac.uk/researchandtrainingunit/centreforqualityimprovement/prescribingobservatory.aspx Their UK audit of screening is reported at Barnes TRE et al. Schizophrenia Bulletin 2007;33(6):1397-1403. We consider that the guidance should recommend screening along these lines and that individuals being prescribed such drugs be encouraged to ask for tests (the audit project produced a card for people to keep where they can record their test results and next appointment dates).	Thank you for your comment. However these suggestions fall outside the remit of this guidance.
Mind		Recommendation 1 / 2		The potential harm from the side effects of neuroleptic drugs also underlines the importance of careful prescribing, and ensuring that people can make informed choices about medication, and are not prescribed higher doses than necessary for longer than necessary. We consider that the guidance should advise professionals to be mindful of minimising these risks when prescribing and in discussions with patients.	Thank you for your comment. This guidance is concerned primarily with the systems that need to be in place to find and provide access to those most at risk. Readers are referred to related NICE guidance for information on the specific nature of interventions for smoking cessation and lipid modification and use of statins.
Norfolk and Waveney Mental Health Trust		1 (rec 3); 2 (challenges) and 3		Important points are made about the difficulty of obtaining evidence for work with these populations. This is, perhaps inevitable given the fact that disadvantaged individuals are less likely to access	Thank you for your helpful comments. In addition to the recommendations, the considerations' section highlights the

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				mainstream services and more likely to perceive them as less relevant to their needs. Any emerging evidence base would need to account for the wealth of variations in practice that are likely to be required to work with the various communities (qualitative methodologies may lend themselves more readily to this). I think it is helpful to emphasise the importance of local initiatives to address local problems and the importance of needs assessments. I also think it would be helpful in section 3 to mention the recognition that many system incentives are geared up to quantify access to mainstream services (so it produces more of what we already have). We need more incentives for genuine community engagement (as we discussed at the implementation meeting).	importance of innovation and the development of local initiatives to address local circumstances.
Norfolk and Waveney Mental Health Trust		Section 1 rec 1	8	I have ethical concerns about registers for people who smoke or are from particular minority ethnic groups. I am aware ethnicity is picked up as a demographic measure but the idea of registers in this respect could be problematic.	Thank you for your comment.
Norfolk and Waveney Mental Health Trust		Section 1 rec 1	8	I have concerns about cold calling with populations who are traditionally difficult to reach. For some this could further alienate them from mainstream services and I think engagement needs to be more carefully considered.	Thank you for your comment. The term cold calling is no longer included as one of the examples in the guidance. However, this does not mean it should not be used if considered appropriate.
Royal College of Nursing		Page 5	5	We are pleased to see that Learning Disability features strongly and those who are in contact with Criminal Justice Services, Immigration/ Detention centres should also be considered.	Thank you for your comment.
Royal College of Nursing		general	7	There will be different issues for people with LD and access to services should be considered when finding clients.	Thank you for your comment. Recommendation 2 in the final guidance is directly concerned with access.
Royal College of Nursing		general	8	There are no registers for LD so they can easily 'slip through the net'. This should be taken into account.	Thank you for your comment. The guidance includes a number of actions within the recommendations that have a bearing on this.
Royal College of Nursing		general	8	Pleased to see Prisons included. There is good evidence that people in prison are a high risk group.	Thank you for your comment
Royal College of Nursing		general	15	The perspectives relating to LD issues are worth strengthening here.	Thank you for your comment

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Royal College of Nursing		general	21	Need to consider access for people with LD to services	Thank you for your comment – please see earlier comment.
Royal College of Psychiatrists (Eating Disorder Section)		General	General	On behalf of the 'eating disorder' section of the Royal College of Psychiatrists, we note that eating disorders carry the highest standardised mortality of any psychiatric diagnosis, hence are likely to contribute to trends in premature death. However, the lack of accurate population statistics can falsely lower the perception of their relevance at a 'public health' level. It will be unsurprising if the proposed review makes no reference to this as an issue. Predicting, hence preventing, such deaths is an inexact science, drawing on an inadequate evidence base. We are proposing setting up a regular National Enquiry into deaths from eating disorders in order to address the knowledge gaps. We have approval within our organisation, from the UK's main 'service user' group, the Eating Disorder Association (BEAT), and also the Mental Health Research Network. We are now seeking approval from the National Patient Safety Agency. In the meantime, the proposed report might acknowledge the knowledge deficit and support our suggested work.	Thank you for your comment and additional information. However, this piece of guidance specifically focuses on smoking cessation and the provision of statins. The issue of eating disorders falls outside this remit.
South Asian Health Foundation		General		We welcome this guideline on addressing cvd mortality particularly in those disadvantaged groups as defined on page 5.	Thank you for your comment.
South Asian Health Foundation		General		Tackling Health Inequalities, as the House of Commons Health Committee (March 2008) highlights, requires a multi agency approach and not just that of the NHS. Hence need for wider consultation and working with other agencies, including the voluntary sector, is vital in reducing health inequalities.	Thank you for your comment. The guidance does highlight the need for partnership working across sectors.
South Asian Health Foundation		General		It should be noted that the imminent 'Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease' guideline will supersede a number of listed recommendations in relation to identification of individuals at high cvd risk and subsequent management with lipid modifying drugs such as statins.	Thank you for your comment. The guidance document does acknowledge this.

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South Asian Health Foundation		General		Voluntary sector screening – requires coordination with NHS models of care delivery to avoid fragmented effort, displacement of responsibility and quality assurance. Voluntary sector engagement is commendable and should be encouraged but must form part of a wider proactive case finding strategy with the ability of the health service to accept referral of individuals into services such as smoking cessation clinics, primary prevention services etc. from programmes such as the South Asian Community Health Empowerment and Education campaign (SACHE) which is an ongoing programme being delivered by the South Asian Health Foundation [www.sahf.org.uk] and The Healthy Hearts Institute [www.healthy-hearts.org.uk]	Thank you for your comment. The guidance does highlight the need for partnership working between the different sectors that are concerned with helping those from disadvantaged backgrounds. Recommendation 4 in the final guidance includes an action to encourage a coordinated approach across sectors.
South Asian Health Foundation			5	Is the Index of Multiple Deprivation the most appropriate tool for all groups – it would seem to have limitations for BME groups? We acknowledge that a single measure of deprivation is unlikely to capture all elements of deprivation in particular that of ethnicity. Particularly given the marked heterogeneity in socio-economic position amongst , for example, the South Asians [Bhopal et al J Pub Hlth Med 2002; 24: 95-105]	The text has been amended to clarify that the index of Multiple Deprivation tool is provided as an example. The guidance acknowledges there are a variety of ways to define disadvantaged areas.
South Asian Health Foundation				It is not simply access to services, but acquisition of services, which is required to make an impact. Reasons for limited access and acquisition might be, but are not necessarily, identical. There is a need for further research in this area.	Thank you for your comment.
South Asian Health Foundation			7	It is unfortunate individuals are referred to as 'clients'.	Thank you for your comment. The guidance document has been amended.
South Asian Health Foundation			8	Currently, there is a lack of systematic ethnic recording within primary care [Gill & Johnson BMJ 1995; 310:890] except for new registrants. This prevents identification of individuals at high risk of cvd. Marked inequalities in health and health care are documented by ethnic group and the scientific, moral, business and legal case for ethnic monitoring is well established.[Gill PS, Kai J, Bhopal RS, Wild S. Health Care Needs Assessment: Black and Minority Ethnic Groups. In Raftery J, Stevens A, Mant J (eds) *Health Care Needs*	Thank you for your comment. and references. The use of primary care registers is one of many suggested methods. The guidance does state that service providers should monitor these methods and adjust them according to local needs.

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				Assessment: The epidemiologically based needs assessment reviews. Third series. Abingdon: Radcliffe Medical Press,2007] Limited ethnic monitoring for all new registrations to general practice was introduced in 2006. This must now be extended to **all** registered patients as well as for the inclusion of language and religion in addition to ethnic group.	
South Asian Health Foundation			8	An innovative smoking cessation pilot study is currently in progress in Birmingham that is addressing the poor uptake of current smoking cessation services by Bangladeshi and Pakistani men (aziz.sheikh@ed.ac.uk). It is likely that this poor uptake of services is rooted in cultural beliefs about smoking and its cessation, as well as the practicalities of service access. This is a concern, because people who use stop smoking services are about four times more likely to stop than are people who do this unassisted. The pilot study aims to tackle some of the main barriers to stop smoking services by redesigning service delivery to be more acceptable to this population. Hence it is evaluating two interventions: trained stop smoking advisor from the local community based in clinics and trained stop smoking advisor from the local community working in an outreach capacity. This pilot is due to finish by December 2008 and further full trial evidence is needed.	Thank you for this information. A list of research recommendations and gaps in the evidence are included in the final guidance.
South Asian Health Foundation			8	Targeted screening for first degree relatives and in primary care has several good examples e.g. Birmingham Sandwell and Solihull Cardiac Network, Sandwell PCT, Sandwell Hospital - have good models of proactive case finding	Thank you for your comment, identifying high risk individuals through family members who have had premature CHD is included in Recommendation 1 of the final guidance..
South Asian Health Foundation			9	We agree that multi-lingual literature should be available but need to highlight health literacy that is the ability of a person to understand information on health matters and the ability to gain access to and navigate through the health care system [Arch Intern Med. 2007; 167:1503-1509]. In addition, the illiteracy rate is higher amongst certain sections of the population and so alternative forms of providing information i.e. DVDs should be available.	Thank you for your comment., providing information in a variety of formats is included in the recommendations.

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South Asian Health Foundation			45	There is data from an observational study (The Khush Dil project) that shows quantitative evidence (albeit not a trial) on the impact of a prevention package on cardiovascular risk factors in South Asians. [Bhopal et al. J Public Hlth 2007;29:388–397] Obviously there is now a need for further robust evaluation.	Thank you for your comment. However we are unable to accept any additional new evidence at this stage in the process for this piece of guidance. We will be able to accept new evidence when the guidance is revised.
University of Birmingham		General		It is unclear why there has been a privileged focus on prescribing of statins. Statins are not the only treatment that reduces incidence of CVD. Antihypertensive treatment is also effective in reducing CVD mortality and is widely underprescribed. Aspirin is effective in primary prevention of CVD and is widely underprescribed despite being recommended in the Joint British Society guidelines. Ref: Hayden M. et al. Aspirin for the primary prevention of cardiovascular events: a summary of the evidence for the U.S. Preventive Services Task Force. Annals of Internal Medicine 2002; 136(2):161-72. Undertreatment of hypertension and underuse of aspirin are greater unmet needs than underuse of statins. In the Sandwell CVD project, even when patients were assessed and identified as eligible for treatment by the project nurse treatment was discussed with the patient and this information was provided to the GP, 75% of aspirin-eligible patients were NOT started on aspirin and 44% of antihypertensive-eligible patients were NOT started on an antihypertensive. Those who were started on an antihypertensive were rarely started on a second one although this was clearly necessary from their pre-treatment blood pressures. Only 32% of patients eligible for a statin were NOT started on a statin. Cont'd	Thank you for your comment. The area of statins was focussed upon following an eight week consultation on the draft scope.
University of Birmingham		General		Ref: Marshall T. How many antihypertensives do patients need to achieve a target blood pressure? Journal of Human Hypertension 2005; 19:317-319.	Thank you for the references.

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				Ref: Marshall T, et al The Sandwell Project: a controlled evaluation of a programme of targeted screening for prevention of cardiovascular disease in primary care BMC Public Health 2008, 8:73.	
University of Birmingham		Recs	7 and 8	Prioritisation of patients to target using simple categorical variables is not sufficient to be of use to a primary care provider or organisation. For example: since 25% of adults smoke, which smokers should be targeted first? Or are they targeted in random order? Clearly those at highest risk should be first. Similarly on page 8 several different approaches are mentioned: a) primary care and general practice registers (to identify people who smoke or who are from particular minority ethnic groups) These registers usually do not record ethnicity. Nor is it useful to simply regard all South Asians as "high risk". Clearly risk is a continuous variable and it should be represented as a continuous variable Ref: Marshall T. Identification of patients for clinical risk assessment by prediction of cardiovascular risk using default risk factor values BMC Public Health 2008, 8:25. b) opportunistic identification during primary care appointments Evidence from the Sandwell CVD project indicates that this is a highly inefficient method of patient identification. Patients are twice as likely to be assessed with active than with opportunistic case finding and 3 times more likely to be started on treatment. Assessment is NOT an end in itself. Ref: Marshall T, et al The Sandwell Project: a controlled evaluation of a programme of targeted screening for prevention of cardiovascular disease in primary care BMC Public Health 2008, 8:73. Cont'd	Thank you for your comment. The goal of the guidance is to provide those with a remit for tackling health inequalities with broad guidance on what systems and principles they should employ to do this. The exact tools to be utilised should be decided at the local level and be in line with local needs.
University of Birmingham				It is better to provide a single ranked list of individuals who should be approached in descending order of priority. This requires a predictive	Thank you for your comment. As you will note from the previous comment this

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				algorithm that allocates each individual a risk score or rank. The simplest way of doing this is to target patients by their predicted CVD risk, since this correlates closely with predicted mortality. This can be calculated from incomplete data and there are several software companies that can do this.	guidance is concerned with providing guidance on the systems and principles that those with a remit for tackling health inequalities should employ.
University of Birmingham		Recommendation 1 finding clients	8	The aim of CVD risk factor assessment is to offer treatment or other interventions, not simply to collect risk factor data. If assessments are to be carried out in "post offices, charity shops, supermarkets, homeless centres, workplaces, prisons and long-stay psychiatric institutions", using places of worship or community health workers, there must be a clear pathway from identification of individuals who need intervention and appropriate care. Without such a pathway this approach constitutes poor practice in screening. Either there must be agreement by existing services (eg: smoking cessation) to accept referrals and to prescribe (eg: GPs) on the basis of these assessments or a new service must be created that will refer and prescribe (eg: nurse prescribers or pharmacist prescribers). If this does not take place GPs will not refer or prescribe on the basis of these assessments. Assessments will be repeated in primary care. Patients will rarely be started on treatment. Even with a project nurse to identify patients eligible for aspirin Thought should also be given to long-term management of patients started on treatment, since the effects of short-term treatment are negligible. Either existing primary care services need to be engaged in this or an alternative service created that will undertake active recall and follow up of patients.	Thank you for your comment. There is a need for joined up working and Recommendation 4 in particular focuses on partnership working as a means for tackling these issues.
University of Birmingham		Recommendation 2 Improving services and retaining people	9	More attention could be given to some simple database searches actions that could be implemented now and would yield substantial results. These are likely to be of benefit to social groups with higher DNA rates and higher rates of diabetes. Current GP databases can easily generate lists of patients who failed to collect repeat prescriptions or attend follow up appointments. Practices should be encouraged to ROUTINELY identify such patients and contact them.	Thank your for your comment. The guidance acknowledges the need for the use of different methods of identification that are applicable to locality in which they are being used.

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				Having now searched (in 2005 and 2007) electronic medical records for patients at high risk of CVD in 9 practices of widely varying size and characteristics, I have found in EVERY practice, instances of untreated individuals whose last recorded systolic BP is >180 mm Hg. Many practices also include untreated patients whose last recorded BP is >200 mm Hg. A common explanation appears to be that patients who fail to collect repeat prescriptions are not identified and are not followed up. This finding mirrors exactly the finding that 0.2% of the UK population have electronic records that are diagnostic of diabetes and a further 0.8% have probable diabetes. These individuals could be identified easily by simple searches of electronic medical records databases. Ref: Holt T. et al Identifying undiagnosed diabetes: cross-sectional survey of 3.6 million patients' electronic records British Journal of General Practice 2008; 58: 192–196.	
University of Birmingham		Recommendation 3 System incentives	10	System incentives are not the only way of effecting change. They may not be the most efficient way of effecting change. Incentives applied to the primary care existing system must compete with other incentives and disincentives. For example, identifying and treating patients adds to primary care workload but does not attract additional resource. Neither the Sandwell project nor the subsequent Solihull project have offered any financial or other incentive to practices. They have simply created a parallel system for identification, assessment and treatment that is integrated with the existing primary care system. The parallel system has only one objective – identify and treat patients at high risk of CVD – and therefore does not encounter the problem of competing demands and competing incentives. There is a case for investigating the efficiency of a variety of approaches to case finding and CVD prevention.	Thank you for your comment. In developing the recommendations the independent public health advisory committee drew on evidence from effectiveness reviews, primary research, expert testimony and cost effectiveness analyses. System incentives are one of a number of recommendations that seek to support and sustain activities aimed at improving the health of those who are disadvantaged.

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University of Glasgow – Section of General Practice and Primary Care				The report is OK as a distillation of what is definitely known in terms of answers to the questions asked, and perhaps that is as far as its brief was intended to go, but I found it limiting in several ways. The proven effectiveness of interventions is obviously important but the real challenge is delivery The guidance does not mention the inverse care law, or its main features – a principal reason why effective interventions are difficult to deliver in deprived areas (see earlier comments, attached again below). Specific interventions have to be placed in context, which means not only the nature of encounters between professionals and patients (context, time, other problems, expectations), but also the systems in which they are working. To whom is the guidance addressed? It uses the language of public health, which may not be the best way of communicating with delivery systems that are most likely to be based in primary care. ("clients" ?). I think a primary care readership might find the report rather patronising in what it recommends, and limited in its understanding of the delivery issues. I found the section on incentives to use services bizarre. I wonder if this comes from the same source of excellent ideas as the idea that choice and consumerism are likely to drive change in deprived areas. The impression is that some influential policy advisors are not very street-wise, in terms of front-line experience. The report appears to have a rather limited concept of "access". What matters is engagement, continuity, flexibility, co-ordination and trust. Ascertainment is only the beginning of the process.	Thank you for your comments The goal of the guidance is to provide those with a remit for tackling health inequalities with broad guidance on what systems and principles they should employ to find and support those most at risk of early death and improve their access to services.. The exact tools and delivery mechanisms to be utilised should be decided at the local level and be in line with local needs.

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				General practice is not the only delivery mechanism, but it does have the structure and potential for coverage, continuity, co-ordination etc. There is a limit to how many services an individual with multiple problems can cope with. The wide panoply of potential initial contact points needs to connect with what happens after initial ascertainment. It may be that some people in deprived areas will respond well to single transforrmative encounters in community pharmacies and shopping centres, but particularly for people with multiple problems, change is likely to be a longer term process. As Tudor Hart put it "initially face to face, eventually side by side". I have lost touch with the new NICE guidelines on statin treatment, but the introduction of ASSIGN, the new CVD risk score for Scotland, which adds deprivation and family history as CVD risk factors, will have the effect of doubling the numbers of high risk men, and trebling the numbers of high risk women in the most deprived 20% of the population. But there is little point in giving time-poor practices this additional caseload, without the resources needed to provide continuity and follow-up. I don't think any professional working in the front line of primary care thinks of their work as "reducing inequalities". That is simply the by-product (which others may note via desk-based epidemiology) of doing the best they can in the circumstances. There is no great secret to this. Policies to narrow inequalities in health, insofar as they work through primary care, need to support patients and professionals to narrow the gap between what currently happens, and what is needed to ensure the benefits of effective interventions are achieved. From a communications point of view, the issue is not to narrow inequalities, it is to improve the volume, process and outcomes of	

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				services serving poor areas. The recommendations overlap with many of the intentions of the Scottish national demonstration project on anticipatory care (*Keep Well*), notionally based on Tudor Hart's exemplar project at Glyncorrwg in South Wales. NICE might wish to explore what Keep Well is doing. My view is that Keep Well has so far only bolted on to primary care a screening approach to ascertainment, employing new staff to do this work, and linking to a plethora of health improvement programmes, without feeding through to mainstream services for continuity and follow-up, or establishing any other mechanism for building on initial progress.	