Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Action on Hearing Loss	**General**		**Introduction** The focus of this guidance on adults aged 40-64 is welcomed but currently hearing loss is overlooked as a health risk factor, despite its prevalence amongst this population, and its negative impact on health and wellbeing, including strong evidence of a link with dementia. We lay out this evidence below.	Thank you for your comment, and for highlighting this important issue. The final scope will include hearing loss and we will include this among the evidence that we search for as the guidance is developed. Please bear in mind that the final guidance and recommendations will depend upon the available evidence.
Action on Hearing Loss	**General**		**Unaddressed hearing loss** Hearing loss is a major public health issue affecting over 10 million people in the UK – one in six of the population. This includes 42% of over 50 year olds who have some form of hearing loss. As our population ages the number of people affected by hearing loss is set to grow and by 2031 there will be more than 14.5 million people with hearing loss in the UK[1]. There is a large problem of unaddressed hearing loss in the UK. On average, people referred for hearing assessment are in their mid-70s and have had a hearing problem for 10 years or more[2]. By the time many people seek treatment, their ability to adapt and benefit from a hearing aid is greatly reduced. The main reason for waiting is that individuals do not consider their hearing to be sufficiently poor. 60% of people aged 75 and over have a	Thank you for this information outlining the extent of hearing loss.

[1] Action on Hearing Loss 'Hearing Matters' 2011
[2] Action on Hearing Loss 'Hearing Matters' 2011

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			substantial hearing impairment, but by this age the ability to adjust and manage hearing loss is reduced[3]. Earlier intervention would ensure that people are supported to manage their hearing loss at an age when they are able to benefit most. A recent population study found that around one in eight people (12%) aged 55-74 years is severely annoyed, worried or upset about their hearing and would benefit from referral for hearing aids, but many of these do not seek help and only 3% of this population currently have hearing aids[4].	
Action on Hearing Loss	**General**		**Personal impacts** Hearing loss has significant personal and social costs. Untreated, it can cause communication problems leading to high levels of social isolation. Research shows that people with hearing loss are likely to withdraw from social activities involving large groups of people and, where they do take part, communication difficulties can result in feelings of loneliness[5]. Hearing loss can have damaging impacts on spouses and families. It can cause isolation and a decrease in joking in families and distancing between couples, including feelings of frustration and a decrease in intimate talk[67].	Thank you for this information on the impact of hearing loss. The PDG will take into account these type of issues when considering the evidence.

[3] Davis, A. et al. 'Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models' *Health Technology Assessment* 2007, 11(42), 1-294
[4] Davis, A. et al. 'Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models' *Health Technology Assessment* 2007, 11(42), 1-294
[5] RNID 'Hidden Crisis' 2009
[6] Brooks, D. N. et al. 'The effects on significant others of providing a hearing aid to the hearing-impaired partner' *British Journal of Audiology* 2001, 35, 165-171
[7] Hallberg, L.R-M. & Barrenas, M-L. 'Living with a male with noise-induced hearing loss: experiences from the perspective of spouses' *British Journal of Audiology* 1993, 27, 255-261

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Research has found that hearing loss can also distance couples as a unit from wider social networks, and that partners of people with hearing loss often feel frustration and loneliness. They report missing out on social activities and companionship[89]. Communication difficulties resulting from unaddressed hearing loss cause problems for people seeking help and treatment for other health issues. For example, our research has found that over a quarter of people with hearing loss have been unclear about their diagnosis after visiting a GP.[10]	
Action on Hearing Loss	**General**		**Hearing loss and other conditions** The social isolation that often results from hearing loss may itself lead to mental ill health. Hearing loss more than doubles the risk of depression in older people[11], and there is strong evidence that hearing loss is particularly associated with cognitive decline[12]. People with mild hearing loss have nearly twice the chance of going on to develop dementia as do people with normal hearing. The risk increases threefold for those with moderate and fivefold for those with severe hearing loss[13]. There is also significant co-occurrence of hearing loss with other long term conditions including cardiovascular disease, diabetes and sight loss, as they	Thank you for your comment.

[8] RNID 'In It Together' 2010
[9] Sherbourne, K. at al. 'Intensive rehabilitation programmes for deafened men and women: an evaluation study' *International Journal of Audiology* 2002, 41, 195-201
[10] Action on Hearing Loss 'Access All Areas?' 2013
[11] Saito, H. et al. 'Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese' *Journal of the American Geriatrics Society* 2010, 58(1), 93-7
[12] Lin, F.R. et al. 'Hearing Loss and Cognitive Decline in Older Adults' *Internal Medicine* 2013, http://archinte.jamanetwork.com/article.aspx?articleid=1558452
[13] Lin, F.R. et al. 'Hearing Loss and Incident Dementia' *Archives of Neurology* 2011, 68(2), 214-220

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			are all experienced widely among older people. Hearing loss leads to problems diagnosing and managing these conditions, increasing their impact, lowering an individual's quality of life and placing unnecessary costs on the NHS.	
Action on Hearing Loss	**General**		**Early intervention** Addressing hearing problems as they occur, frequently in mid-life, has significant and wide-ranging benefits. It can resolve problems with communication and social isolation, bring people closer to their partners, families and communities, lower the risk of depression and overcome barriers to accessing health and social care services[14]. Diagnosing and managing conditions such as cardiovascular disease, diabetes and sight loss becomes easier and less costly, as patients are able to access services and communicate with professionals. Getting good, effective care earlier improves quality of life and saves money in the longer term. Timely management of hearing loss would be particularly likely to have a large impact in terms of minimising the risk and impact of dementia. Although research is needed to better understand the relationship, it has been suggested that managing hearing loss, for example, through hearing aids, may slow cognitive decline[15,16]. Furthermore, with long term conditions such as dementia, it can often become more difficult to diagnose and manage hearing loss if it is discovered at a later stage. For example, one study of care home residents, many of whom had	Thank you for your comment. The PDG will take into account these types of issues when considering the evidence.

[14] Sherbourne, K. at al. 'Intensive rehabilitation programmes for deafened men and women: an evaluation study' *International Journal of Audiology* 2002, 41, 195-201
[15] Lin, F.R. et al. 'Hearing Loss and Cognitive Decline in Older Adults' *Internal Medicine* 2013, http://archinte.jamanetwork.com/article.aspx?articleid=1558452
[16] Lin, F.R. et al. 'Hearing Loss and Incident Dementia' *Archives of Neurology* 2011, 68(2), 214-220

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			dementia, found that only 5% were able to complete a normal hearing assessment[17], resulting in any hearing loss not being diagnosed. There is also a risk of hearing loss being misdiagnosed as other conditions, including dementia[18]. If hearing loss is diagnosed earlier, people have more time to adapt, making it easier and less costly to manage the hearing loss and any other conditions.	
Action on Hearing Loss	**General**		**Conclusion** There is clearly a need for hearing loss to be recognised as a public health priority for 40-64 year olds, and for its inclusion in this public health guidance, and to explore interventions to motivate people to address their hearing loss earlier and improve their quality of life.	Thank you for your comment. Hearing loss will be included in the scope.
AFT, the Association for Family Therapy and Systemic Practice	General		This response is submitted by AFT, the Association for Family Therapy and Systemic Practice (www.aft.org.uk). AFT is the UK's leading organisation for professionals trained to work therapeutically with families and other networks of care. AFT's membership is multi-disciplinary, and includes Family and Systemic Psychotherapists (also known as Family Therapists), psychologists, psychiatrists, GPs, occupational therapists, health visitors, social workers, teachers, and others committed to delivering high quality care by developing their systemic practice skills and understandings	

[17] Burkhalter, C.L. et al. 'Examining the effectiveness of traditional audiological assessments for nursing home residents with dementia-related behaviors' *Journal of American Academic Audiology* 2009, 11(9), 529-38

[18] Boxtel van, M.P.J. et al. 'Mild Hearing Impairment Can Reduce Verbal Memory Performance in a Healthy Adult Population' *Journal of Clinical and Experimental Neuropsychology* 2000. 22(1), 147-154

Public Health Guidance

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AFT, the Association for Family Therapy and Systemic Practice	General		The Draft Scope appears comprehensive and the recognition that different sub-populations may have different issues for and responses to intervention is to be welcomed	Thank you for your comment.
AFT, the Association for Family Therapy and Systemic Practice	General		Equality and Diversity considerations could be strengthened by including measures to address stigma and lack of knowledge about dementia within some communities, including some minority ethnic communities. It is widely recognised that these factors currently affect access to services and 'living well' programmes. Culturally sensitive community outreach services are more likely to reach communities and groups currently under-represented in clinic based and majority population services.	Thank you for your comment. Equity and the impact of interventions across a range of groups and populations will be considered as we identify and appraise the evidence that will inform this guidance. In addition, we will carry out an equity impact assessment on our scope and development process to help ensure that the issues you raised are given due consideration,
AFT, the Association for Family Therapy and Systemic Practice	3 Need for Guidance	P3 b	AFT welcomes the draft scope's recognition that 'Age-related physiological changes can be made worse by personal, social and environmental circumstances.' As this section makes clear, those in this 'mid life' age group may be caring for younger and older relatives and working themselves or looking for employment. The complexities of family caring in times of economic hardship will impact on people's leisure time, motivation and social engagement and well-being. AFT requests that the scope acknowledges the importance of access to therapeutic supports for families experiencing difficulties in their lives and relationships. The link between relational health and well being is widely acknowledged. Systemic family therapy, and support from staff with systemic	Thank you for your comment. Thank you for your comment. The scope template limits the amount of information that can be included. This type of

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			practice skills and understandings, will help family members and others in close relationship understand each other's needs and experiences and support each other constructively. Family support helps increase people's adherence to and engagement in healthy living programmes.	evidence would be identified for and included in the review addressing the barriers and facilitators to uptake of healthy behaviours (Key question 3) – where appropriate evidence on the issue you raise is identified, the Public Health Advisory Committee (PHAC) will consider it as they develop recommendations in this area..
AGILE: Chartered Physiotherapists working with Older people	General		AGILE welcomes the scope of this guidance. We recognise that the need for public health guidance to improve the physical abilities of adults as they move towards and into older age is vital. It is important to focus on behaviours in middle-age that can be targeted to reduce risk in later life.	Thank you for your comment.
Alzheimers Society	General		Alzheimer's Society strongly supports the development of public health guidance on delaying the onset of dementia in later life. We are pleased that it is a specific focus for this scope, and would be pleased to work further with NICE in the development of this guidance. Dementia is not often cited in public health messages even where there is a prove link of benefit (eg. promoting exercise). Indeed, there is little public discussion of the prevention of dementia beyond articles in the popular press which often oversimplify the findings of an isolated study and lead to general misunderstanding of the benefits of particular foodstuffs or activities at the detriment of areas where there is better evidence of benefit. Where dementia is included in public health interventions, such as a pilot inclusion in the NHS Health Check, this has received positive feedback.	Thank you for your comment. Thank you for your comment. We agree that this is an important area for guidance.

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			As a disease feared by the over 55s more than cancer or heart disease, we believe that there could be immediate action, with dementia cited in public health messages promoting a healthy lifestyle.	Thank you for your comment.
Alzheimers Society	General		The draft scope proposes to focus on interventions with adults aged 40-64, and the questions ask if this is the most appropriate age range to focus on. We believe that focusing on this age group would mean that risk factors can be modified. The main modifiable risk factors for dementia have been identified as: • Obesity in mid-life • Smoking • Alcohol use • Low physical activity Additional medical factors which could be modified or managed by lifestyle behaviours include: • Hypertension in midlife • High cholesterol in midlife • Diabetes • Stroke The existing evidence suggests that these factors have an effect on the development of dementia from mid-life, so interventions to encourage different behaviours from midlife would be helpful. However, we are concerned at the abrupt cut off at 65, and feel that healthy lifestyles, particularly the maintenance of healthy lifestyles in the face of other	Thank you for your comment. Thank you for your comment. Thank you for your comment. The referral from the

Public Health Guidance

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			health concerns, could be usefully encouraged in older people as well as those in middle age. There are particular challenges which face older people in maintaining healthy lifestyles should they develop a condition. For example, older people with mobility difficulties will need more opportunities suitable to their needs in order to maintain levels of physical activity. We feel that a scope extended to include this would better promote equality of opportunity on the grounds of age and disability.	Department of Health is specific to midlife. A referral has also been received from DH for guidance on 'Primary, secondary and tertiary interventions to promote mental well being and independence of older people' which we anticipate will address many of the issues that you raise. You can read more about this planned guidance here: http://guidance.nice.org.uk/PHG/65 , and we would encourage your organisation to register as stakeholders for it.
Alzheimers Society	General		In addition, we feel that exploring which interventions may help prevent or delay the onset of dementia among particular groups who have comorbidites which make them more likely to have dementia would be helpful. There is link between kidney disease and dementia, and some neurological conditions (eg. Multiple Sclerosis, Parkinson's) and dementia. In addition, people with learning disabilities also have a higher incidence of dementia. Many people with dementia also have depression in advance of developing cognitive symptoms. A review of the evidence could helpfully examine what the causal links are in these cases and whether effective treatment of these conditions could have an impact on developing dementia. We feel that a scope extended to include this would better promote equality of opportunity on the grounds of disability.	Thank you for your comment. Management of chronic conditions is not part of the referral from DH. Management of chronic conditions is covered by NICE clinical guidelines – you can find the full list of published guidelines here: http://www.nice.org.uk/guidance/cg/index.jsp A separate public health referral

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				has been received from DH for guidance on 'Primary, secondary and tertiary interventions to promote mental well being and independence of older people' which will address some of the issues you raise in an older population. http://guidance.nice.org.uk/PHG/65
Alzheimers Society	General		In addition, we feel that exploring which interventions help maintain physical health among people who already have cognitive impairments could be useful in promoting healthy ageing among people who have dementia. This may prevent them from developing additional health concerns which can be more difficult to manage. We feel that a scope extended to include this would better promote equality of opportunity on the grounds of age and disability.	We agree that this is important. We anticipate that secondary prevention – including delaying the progression of existing conditions, as well as preventing or delaying comorbidities - will be addressed in a separate piece of guidance.
Alzheimers Society	General		The draft scope asks if the proposed evidence reviews and economic analysis allow us to address the issues outlined in the scope. We believe the proposed evidence reviews will go some way to address the issues outlined in the scope. We suggest that NICE work with existing bodies, including the Alzheimer's Society Vascular Dementia Systematic review group and others, to explore the existing work being undertaken in this area. Alzheimer's Society also worked with a group of public health advisers to map the evidence for risk factors for dementia across primary, secondary and	Thank you. We will be issuing a call for evidence alongside the final scope, and we would be grateful if you could submit details of this work so that we

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			tertiary prevention. We are happy to share this work with NICE.	may take it into account as we appraise the evidence. The call for evidence will be emailed to all stakeholders, and you will also be able to find details here: http://guidance.nice.org.uk/PHG/64
			We suggest that the intervention or set of interventions which are modelled for the economic analysis is chosen following a review of the evidence. Our understanding of the existing evidence suggests the best way of reducing the risk of dementia is through taking regular exercise.	Thank you for your comment. Our usual procedure is that the findings of the evidence reviews and the views of the advisory group inform the specific strategies in the economic modelling. You can read more about our methods and processes here: http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/developing_nice_public_health_guidance.jsp
Beth Johnson Foundation	General		It is right to target the mid-life age group in terms of delaying disability and long term conditions. There are often transition points in this period of life which initiate a process of self-reflection and provide opportunities to make changes that will benefit health and well-being in the long run. E.g. children leaving home, grandchildren being born and death of parents provide a	Thank you for your comment. Where we are able to identify appropriate evidence on the issues you raise, the Public Health Advisory Committee

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			personal impetus to take stock and make changes. The experience of the Beth Johnson Foundation in our mid-life work is that people of that generation benefit from interventions that take place in easily accessible settings in their own communities and are 'non-clinical'. We ran a mid-life health check programme that was successful and engaged with people on all sorts of levels. People engaged with the project because it was on their 'turf' and they could access a check, information and guidance as they went about their day to day business. There is a need to find that personal motivation for change, to make health messages understandable (translation of knowledge and not just transfer) and to make healthy lifestyles 'fun'.	(PHAC) will consider it as they develop this guidancet. We will be issuing a call for evidence alongside the final scope, which will be emailed to stakeholders. You will also be able to find details about it here http://guidance.nice.org.uk/PHG/64: If there is an evaluation of this programme we would be grateful if you would submit it in response to our call for evidence.
Beth Johnson Foundation			By now most of us aware of the risk factors but often people still don't know how to apply it to their own lives.	Thank you for your comment. The work will include an

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			And it should take a holistic approach – often the issues are in silos e.g. nutrition or physical activity. The translation part would be 'what does a reasonably healthy lifestyle look like?'; 'how do I translate that to my own life – given where I live and where I work?'	investigation of models of delivery, which we hope will address some of the issues you raise.
British Academy of Audiology	General		There is no mention of hearing loss in this. There is now a well-established relationship between hearing loss and dementia. Although this has not been shown to be causal, there is a strong causal association between hearing loss and social withdrawal, lack of social and other interaction and other risk factors for both dementia and other disability. There have been few intervention studies and no randomised control trials studying the impact of treating hearing loss in terms of delaying dementia, but intervention with hearing aids and rehabilitation is both a cheap and highly cost-effective measure. Now would be the time to properly assess the benefits in terms of long-term cognition. The focus on your guidance on adults aged 40 – 64 is entirely appropriate as this is the age group where the optimisation of hearing will likely produce the most gains, especially in terms of enhancing cognitive capacity during ageing. Your evidence collection, including studies of economic impact should embrace the question of hearing loss in the ageing population and their access to hearing care in the community. Hearing loss also impacts severely on the ability of individuals to manage their health conditions. Patients report inability to hear their health care professionals properly as playing a significant role in their difficulties complying with instructions and care plans. Therefore, appropriate treatment of hearing loss is vital to ensure that other health interventions to delay onset of dementia and other disabilities are optimised. Finally, many of the tests for dementia are reliant on audition. Appropriate screening of hearing is essential to ensure that it is dementia, not hearing loss,	Thank you for your comment. The final scope will include hearing loss.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			that is responsible for findings.	
British Association of Audiovestibular Physicians	General		Hearing Loss and Cognitive Decline Recent epidemiological data have suggested a strong causal relationship between age-related hearing loss and cognitive decline in older people. These findings are not referred to in your scoping document. Data demonstrate that fewer than15% of adults with a clinically significant hearing loss use hearing aids and that these aids are provided many years after the onset of hearing loss. The wider consequences of hearing loss on the health and functioning of older adults are now beginning to emerge from epidemiologic studies. Research from large epidemiological data sets (ie the National Health and Nutritional Examination Surveys, the Health Aging and Body Composition Study, and the Baltimore Longitudinal Study of Aging) clearly demonstrates that hearing loss is independently associated with poorer cognitive functioning, accelerated rates of brain atrophy as measured on MRI, greater cognitive decline, and increased risk of incident dementia. More importantly, the impact of timely hearing rehabilitative interventions on delaying cognitive decline and dementia in older adults may be highly significant and such interventions require further research to inform clinical practice and shape NICE guidance. The focus on your guidance on adults aged 40 – 64 is appropriate as this is the age group where the optimisation of hearing is likely to produce the most gains, especially in terms of enhancing cognitive capacity during ageing. Your evidence collection, including studies of economic impact should embrace the question of hearing loss in the ageing population and their access to hearing care in the community. REFERENCES:	Thank you for your comment. The evidence review investigating associations with dementia will include large epidemiological data sets. Thank you for your comment.

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Stakeholder Comments Table

21st March 2013 – 18th April 2013

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			Lin FR et al hearing loss and incident dementia Arch Neurol 2011, Feb;68(2): 214-20 Lin FR et al hearing loss and cognition among older adults in the United States J. Gerontol, A Biol Sci med Sci 2011. Oct 66(10): 1131-6 Lin FR, hearing loss and cognitive decline in older adults, JAMA Intern Med 2013, Feb 25, 173 (4): 293-9Lin FR Hearing loss in older adults: who's listening? JAMA 2012, Mar 21; 307(11):1147-8 Yamasoba T et al Current concepts in age-related hearing loss: epidemiology and mechanistic pathways Hear Res 2013, Feb 16 (E pub ahead of print)	
British Society of Hearing Aid Audiologists (BSHAA)	**GENERAL**		There is an important omission from this draft scope document. There no inclusion or even acknowledgment of the increasing evidence about the relationship between unaided hearing loss, cognitive decline and increased risk of incident dementia:- • Hearing Loss and Incident Dementia. Lin et al. Arch Neurol. 2011;68(2). • Popelka et al.The Epidemiology of Hearing Loss Study. J Am Geriatr Soc. 1998;46. • Tun et al. Aging, hearing acuity, and the attentional costs of effortful listening. Psychol Aging. 2009;24. • Ronnberg et al. Hearing loss is negatively related to episodic and semantic long-term memory but not to short-term memory. J Speech Lang Hear Res. 2011;54. • What do we really know about hearing loss and cognitive function? Chung K. Hear Jour. 2012:65(01).	Thank you for your comment. The final scope will include hearing loss.
British Society of Hearing Aid Audiologists (BSHAA)	**GENERAL**		Any assessment of cognitive function should be routinely preceded by or certainly include a hearing test (pure-tone audiometry) but this is largely a reactive measure. As a preventative measure hearing tests should be as	Thank you for your comment. Cognitive assessment is covered in the NICE Clinical Guideline on

Public Health Guidance

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Stakeholder Comments Table

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			routine for adults (certainly for those aged 50 years or more) as sight tests and dental health checks:- • An economic evaluation of screening 60- to 70-year-old adults for hearing loss. Morris et al. J Public Health.2013.35 (1). • Davis et al. Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment. 2007.11(42).	Dementia http://www.nice.org.uk/nicemedia/live/10998/30317/30317.pdf
British Society of Hearing Aid Audiologists (BSHAA)	**GENERAL**		Unaided hearing loss is associated with activity limitations and participation restrictions leading to social isolation, loneliness, depression, reduced mental and physical activity and potential loss of employment or premature retirement from work:- • Arlinger S. Negative consequences of uncorrected hearing loss – a review.2003.Int J Audiol.42 (Suppl 2). • Shield B. Evaluation of the social and economic costs of hearing impairment. A report for Hear-It AISBL. Belgium. 2006. We are strongly of the view that this proposed public health guidance must include hearing tests to precede or to be part of even the most preliminary assessment cognitive function. However, we feel equally strongly that routine hearing tests, even at screening level, for all adults aged 50 years or older would be an important preventative measure.	Thank you for your comment.
Cambridge Institute of Public Health (CIPH)	General		Suitability of 40-64 age range chosen as the focus of this guidance. This age range important but there is evidence regarding mitigation of frailty for the age range of 65 years and older. It is important to stratify the older population into coherent prognosis based case group for personalising intervention, avoiding crude 'ageist' subdivisions.	Thank you for your comment. The referral from the Department of Health was for a focus on midlife. However, the scope acknowledges the need for a degree of flexibility in relation to younger groups at increased

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			There is contradictory evidence on several common risk factors linked to preventive interventions in the older population as a whole, and in specific subgroups, such as relatively young groups with little co-morbidity through to frail groups with short life expectancies. Well-known risk factors such as blood pressure and cholesterol concentrations tend to lose predictive value in later life or even appear protective. Different risk patterns vary and the reasons for paradoxical associations are unclear. Consequently, we can't target preventive interventions according to the risk or prognostic characteristics shared by a sub-group of the older people. And we can't develop tailored interventions to deal with the fact that the relative preventive effect of - or the capacity to benefit from - an intervention varies across patient groups. Prevention and risk reduction in later life can be highly effective and cost-effective, if well targeted. However, the older population is diverse in terms of health status and older people (especially with co-morbidities) are frequently excluded from randomised trials. Given current demographic trends, health systems need to accommodate the increasing number of older people who may or may not be suitable for more aggressive management and it is essential that they can monitor whether provision is appropriate rather than simply implicitly ration by not considering older people for appropriate interventions and or prevention measures.	risk. A referral has also been received from DH for guidance on 'Primary, secondary and tertiary interventions to promote mental well being and independence of older people' which we anticipate will address many of the issues that you raise. You can read more about this planned guidance here: http://guidance.nice.org.uk/PHG/65, and we would encourage your organisation to register as stakeholders for it. The referral from the Department of Health is limited to midlife. Please see previous response.
Cambridge Institute of Public Health (CIPH)	General		What age range should the guidance focus on instead? There is a benefit to including/focussing on older end of spectrum as mentioned above (Clegg, Young et al. 2013).	Please see previous response about the focus of the DH referral. It is also necessary to keep the work manageable within the resources available.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

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Cambridge Institute of Public Health (CIPH)	General		Will the proposed evidence reviews and economic analysis allow us to address the issues outlined in the scope? We do not understand why the guidance is excluding those who are being treated for chronic non-communicable condition or who have a disability associated with a modifiable lifestyle risk factor. This approach is likely to exclude a significant proportion of the population who may be able to benefit from an intervention, specifically in the younger members of the 40-64 age group. We suggest they be included as a vulnerable subgroup.	The scope only excludes people with a condition or disability from interventions aimed at prevention that condition or disability. A second piece of guidance is planned to address secondary prevention. Please see the footnote on page 7 of the draft scope.
Cambridge Institute of Public Health (CIPH)	General		Asked to comment on equality of opportunity. Chronic conditions and disability can overlap and yet chronic conditions and disability associated with a modifiable lifestyle risk factor are excluded in scope. Including chronic conditions as a vulnerable subgroup would increase the ability of this guidance to include disabled people.	Please see previous response. The referral from the DH is about prevention. Management of chronic conditions is covered by NICE clinical guidelines.
Cambridge Institute of Public Health (CIPH)	3f)	Page 4	Confusing wording about QALYs and quality of life. Could imply that QALYs and quality of life are synonymous	Thank you for your comment. This has been corrected in the final scope.
Cambridge Institute of Public Health (CIPH)	4.1.1	Page 5	Definition of disadvantaged group referred to here not defined. We agree that aged 39 and younger from disadvantaged populations should be included but the definition of 'disadvantaged' should be clear.	Thank you for your comment. We have clarified this in the draft scope.
Cambridge Institute of Public Health (CIPH)	4.2.1		Please define 'principle and relevant complementary and alternative measures or approaches'.	Thank you for your comment. This text is part of the standard scope template.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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			We hope that all approaches included in this guidance must be scientifically peer reviewed evidence based, including 'complementary and alternative' approaches.	
College of Optometrists	General		Sight is the sense people of all ages fear losing most and 1 in 5 people aged 75 and 1 in 2 aged 90 and over are living with sight loss.[19] Sight loss is a severe disability and can have devastating pervasive effect on all aspects of life. There is a link between sight loss and reduced wellbeing. Over one-third of older people with sight-loss are also living with depression.	Thank you for your comment the final scope will include sight loss.
College of Optometrists	General		We would stress the importance of interventions that encourage regular eye examinations with an optometrist as important healthy lifestyle behaviour. The vast majority of cases of sight-threatening, non communicable eye diseases are detected through eye examinations by optometrists and early detection is a key factor in improved patient outcomes. This is particularly important for glaucoma which is often asymptomatic in its early stages though already damaging vision and for age related macular degeneration which can progress rapidly making prompt diagnosis and treatment key.	Thank you for your comment. Issues such as intervention type, their configuration and delivery will be covered by the evidence reviews and considered by the Public Health Advisory Committee as they develop the guidance.
College of Optometrists	Section 4.3, question 3	7	Encouraging older people to have regular eye examinations should help reduce falls. Visual impairment is associated with a significant increased risk of falls and as well a reduced ability to live independently[20]. Falls and fractures in the over 65s account for four million hospital bed days each year in England and dementia, frailty, diabetes and other conditions associated with age can drastically increase the risk of falls. NICE has also identified the importance of	Thank you for your comment. The referral from the Department of Health was for a focus on midlife. A referral has also been received from DH for guidance on 'Primary, secondary and

[19] Access Economics (2009) Future Sight Loss 1

[20] College of Optometrists & British Geriatrics Society (2011) *The Importance of Vision in Preventing Falls*. Available from http://www.college-optometrists.org/en/utilities/document-summary.cfm/docid/99A3825F-3E6C-44DA-994D4B42DC1AF5A4

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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			assessing vision to prevent falls. NICE CG21, "Falls: The assessment and prevention of falls in older people" stipulates visual impairment as core to the Multi-factorial falls risk assessment.	tertiary interventions to promote mental well being and independence of older people' which we anticipate will address some of the issues that you raise. You can read more about this planned guidance here http://guidance.nice.org.uk/PHG/65: , and we would encourage your organisation to register as stakeholders for it.
College of Optometrists	Section 4.3, question 3	7	There is anecdotal evidence that people with dementia may be more prone to eye disease but less likely to have those eye problems detected and treated effectively. Therefore, regular eye examinations for people with dementia appears to be an important healthily lifestyle behaviour that could improve dementia outcomes.	Thank you for your comment. The referral from the DH relates to the prevention of dementia. Management of dementia will not be part of this work and falls under the remit of other parts of NICE – you can read NICE's recent quality standard on dementia here: http://guidance.nice.org.uk/QS1
College of Optometrists	Section 4.3	7	Lifestyle choices mentioned in the guidance can have a clear benefit to reduce the risk of sight loss: • Smokers have triple the incidence of age-related macular degeneration compared with non-smokers[21] and smoking is strongly associated with cataracts[22].	Thank you for this information. The final scope will include interventions that address these behaviours.

[21] Cong, R , et al (2008). Smoking and the risk of age-related macular degeneration: a meta-analysis. *Ann Epidemiol*; 18:647–656.

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			A poor diet also puts your sight at risk - eye friendly nutrients found in many fruit and vegetables and fatty acids derived from fish can all help to protect your sight[23]. Regular exercise - the eyes need oxygen to stay healthy and comfortable. Aerobic exercise can increase crucial oxygen supplies to the optic nerve and lower pressure in the eye. Too much alcohol can interfere with your liver functions and reduce the production of glutathione – an important anti-oxidant for the eye. Glutathione prevents a particular kind of cell damage called glycolysation, which can trigger the onset of cataract, glaucoma and diabetic retinopathy[24].	
College of Optometrists	Section 4.3	8	We welcome the fact that the guidance will consider social determinants and feel that the 40-64 age-bracket will need to remain flexible as certain chronic eye conditions have a pre-disposition to certain ethnic groups or are drastically increased by demographic prevalence of deprivation. People in poorer socio-economic groups are more likely to suffer from poor ophthalmic health and less likely to access services[25],[26]. So, for example, it may be worthwhile encouraging groups particularly at risk of eye disease, such as African-Caribbean people with myopia and a family history of glaucoma, to have regular sight tests long before they are 40.	Thank you for your comment.

[22] Kelly, SP, et al (2004). Smoking and blindness: strong evidence for the link, but public awareness lags. *BMJ*; 328:537–8

[23] Brian Chua et al, Dietary Fatty Acids and the 5-Year Incidence of Age-related Maculopathy.

[24] Wong et al, *Alcohol and Eye Diseases*, Surv Ophthalmol. 2008 Sep-Oct;53(5):512-25,

[25] Fraser et al (2001) Deprivation and late presentation of glaucoma: case-control study. *BMJ* 2001;322:639 doi:10.1136/bmj.322.7287.639

[26] Saidkasimova, S et al (2009) Clinical science: Retinal detachment in Scotland is associated with affluence. *Br J Ophthalmo*l;93:1591-1594 doi:10.1136/bjo.2009.162347

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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College of Optometrists	Section 4.3	8	Ethnicity is a factor in eye conditions; for example, white and Chinese populations are more susceptible to AMD[27] whereas South Asian and African-Caribbean ethnic groups are at greater risk of developing diabetic retinopathy[28]. African-Caribbean people are also at higher risk of developing glaucoma[29].	Thank you for your comment. The Public Health Advisory Committee will consider the effectiveness and cost effectiveness of interventions, as well as appropriate models for service delivery, across the whole population of people in defined mid-life, and taking into account evidence about variations in access, impact and effectiveness for different groups in the population.
College of Optometrists	General		Thanks to the frontline nature of the profession, and the high levels of patient coverage, optometrists are in a fortuitous position to help deliver public health messages on the lifestyle choices mentioned, especially in relation to the effect of smoking on eye health. Research elsewhere suggest the public have little awareness that smoking increases the risk of sight loss and that such campaigns can be effective[30]; especially among teenagers who are more scared of losing sight than of lung or heart disease[31]	Thank you for your comment.

[27] Klein, R et al (2006). Prevalence of age-related macular degeneration in 4 racial/ethnic groups in the multi-ethnic study of atherosclerosis. *Ophthalmology* 113(3), 373-380

[28] Diabetes UK (2004) *Diabetes in the UK*, www.diabetes.org.uk/Documents/Reports/in_the_UK_2004.doc

[29] Wadhwa, S & Higginbotham, E.J (2005), Ethnic differences in glaucoma: prevalence, management and outcome. *Current Opinion in Ophthalmology*, 16:101-106.

[30] Carroll, T, Rock, B. (2003) Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement execution and programme placement. *Tobacco Control* ; 12(Suppl II):ii40–ii44

[31] Moradi, P, et al (2007). Teenagers' perceptions of blindness related to smoking: a novel message to a vulnerable group. *Br J Ophthalmol*; 91:605–607.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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Department of Health	General		Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
ENT UK			Recent epidemiologic data suggests a strong causal relationship between age-related hearing loss and cognitive decline in older people and these findings are not referred to in your scoping document. Epidemiologic data demonstrates that <15% of adults with a clinically-significant hearing loss use hearing aids and that these aids are provided many years after the onset of hearing loss. The wider consequences of hearing loss on the health and functioning of older adults are now beginning to emerge from epidemiologic studies. Research form large epidemiological data sets (ie the National Health and Nutritional Examination Surveys, the Health Aging and Body Composition Study, and the Baltimore Longitudinal Study of Aging) clearly demonstrates that hearing loss is independently associated with poorer cognitive functioning, accelerated rates of brain atrophy as measured on MRI, greater cognitive decline, and increased risk for incident dementia. More importantly, the impact of timely hearing rehabilitative interventions on delaying cognitive decline and dementia in older adults may be highly significant and such interventions require further research to inform clinical practice and shape NICE guidance. The focus on your guidance on adults aged 40 – 64 is entirely appropriate as this is the age group where the optimization of hearing will likely produce the most gains, especially in terms of enhancing cognitive capacity during ageing. Your evidence collection, including studies of economic impact should embrace the question of hearing loss in the ageing population and their access to hearing care in the community. Evidence/References Lin FR et al hearing loss and incident dementia Arch Neurol 2011, Feb;68(2):	Thank you for your comment. The final scope will include hearing loss.

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			214-20 Lin FR et al hearing loss and cognition among older adults in the United States J. Gerontol, A Biol Sci med Sci 2011. Oct 66(10): 1131-6 Lin FR, hearing loss and cognitive decline in older adults, JAMA Intern Med 2013, Feb 25, 173 (4): 293-9Lin FR Hearing loss in older adults: who's listening? JAMA 2012, Mar 21; 307(11):1147-8 Yamasoba T et al Current concepts in age-related hearing loss: epidemiology and mechanistic pathways Hear Res 2013, Feb 16 (E pub ahead of print)	
MRC Institute of Hearing Research	**General**		Recent epidemiologic data suggests a strong causal relationship between age-related hearing loss and cognitive decline in older people and these findings are not referred to in your scoping document. Epidemiologic data demonstrates that <15% of adults with a clinically-significant hearing loss use hearing aids and that these aids are provided many years after the onset of hearing loss. The wider consequences of hearing loss on the health and functioning of older adults are now beginning to emerge from epidemiologic studies. Research form large epidemiological data sets (i.e. the National Health and Nutritional Examination Surveys, the Health Aging and Body Composition Study, the Baltimore Longitudinal Study of Aging and the Berlin Aging Study) clearly demonstrates that hearing loss is associated with poorer cognitive functioning (Lindenberger & Baltes, 1994), accelerated rates of brain atrophy as measured on MRI (Peelle at el., 2011), greater cognitive decline (Lin, 2013), and increased risk for incident dementia (Lin et al., 2011). Moreover, tightly controlled experimental studies have shown that poorer cognitive performance in older listeners can be explained and indeed reversed when hearing loss is taken into account (e.g., Schneider et al., 2005). The impact of timely hearing rehabilitative interventions on reducing the cognitive burden of hearing loss and delaying cognitive decline and dementia in older adults may be highly significant. However, such interventions require further	Thank you for your comment. The final scope will include hearing loss.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			research to inform clinical practice and shape NICE guidance. The focus on your guidance on adults aged 40 – 64 is entirely appropriate as this is the age group where the optimization of hearing will likely produce the most gains, especially in terms of enhancing cognitive capacity during ageing. Your evidence collection, including studies of economic impact should embrace the question of hearing loss in the ageing population and their access to hearing care in the community. Lin FR et al hearing loss and incident dementia Arch Neurol 2011, Feb;68(2): 214-20 Lin FR et al hearing loss and cognition among older adults in the United States J. Gerontol, A Biol Sci med Sci 2011. Oct 66(10): 1131-6 Lin FR, hearing loss and cognitive decline in older adults, JAMA Intern Med 2013, Feb 25, 173 (4): 293-9Lin FR Hearing loss in older adults: who's listening? JAMA 2012, Mar 21; 307(11):1147-8 Yamasoba T et al Current concepts in age-related hearing loss: epidemiology and mechanistic pathways Hear Res 2013, Feb 16 (E pub ahead of print) Lindenberger, U. & Baltes, P. B. (1994). Sensory functioning and intelligence in old age: A strong connection. *Psychology and Aging, 9(3)*, 339-355. Peelle, J.E., Troiani, V., Grossman, M., & Wingfield, A. (2011). Hearing loss in older adults affects neural systems supporting speech comprehension. *Journal of Neuroscience, 31(35)*, 12638-12643. Schneider, B.A., Daneman, M. & Murphy, D. R. (2005). Speech comprehension difficulties in older adults: Cognitive slowing or age-related changes in hearing? *Psychology and Aging, 20(2)*, 261-271.	Thank you for your comment.
National LGB&T Partnership	General		The guidance needs to make clear that disadvantaged groups are not one homogenous group, but include equality groups that may experience further	Thank you for your comment. The groups in the scope are given as

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			disadvantage, for example lesbian, gay, bisexual and trans (LGB&T) people. The focus on ethnicity, gender and socio-economic status is too restrictive. Other equality groups should be referenced in the guidance so that their inclusion is explicit. The guidance needs to explain that these equality groups are made up of different protected characteristics that may experience multiple-disadvantage.	examples. Exploration of subgroups will be directed by the evidence. NICE has clear procedures for dealing with equality issues, including completion of an equity impact assessment on all public health guidance. Please see the NICE revised equality scheme and the CPH methods manual for further details.
National LGB&T Partnership	3	3	The health risks presented all relates to the general population, and does not take account of the evidence relating to health inequalities experienced by protected characteristic groups, e.g. LGB&T people. A body of evidence shows higher incidence of smoking, alcohol and drug use, and eating disorders among LGB&T communities, all of which relate to the need for guidance as presented in section 3.	Please see previous response.
National LGB&T Partnership	4.1.1	5	This section mentions disadvantaged groups, but there is no definition of this given in the document. A definition of disadvantaged groups needs to include those with protected characteristics, such as LGB&T people who may have lower life expectancy than the general population. Little research has been conducted into life expectancy among LGB&T communities, however a body of evidence shows higher incidence of smoking, alcohol and drug use, and eating disorders, all of which would lead to lower life expectancy.	Please see previous response.
National LGB&T Partnership	4.2.1	5-6	The definition of disadvantaged groups needs to include equality groups, such as LGB&T people, who may be more at risk of these conditions in later life. The guidance needs to make clearer that disadvantaged groups will include communities of identity (such as LGB&T communities) as well as geographic	Please see previous response.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			communities. Targeted interventions will result in improved outcomes, but the evidence base needs to be understood in order to support such interventions. Interventions delivered by the voluntary sector will be essential to reducing risk.	
National LGB&T Partnership	4.3	7-8	The Expected Outcomes should also measure isolation and level of interaction with someone's community, which may not be geographically focused. For example, fear of travel or leaving one's home may impact on a person's mental health and physical health. The outcomes should also measure improvements by equality group, achieved through monitoring protected characteristics such as the sexual orientation and gender identity of patients. This will ensure that health inequalities between groups are reduced, as well as the health of the overall population improved.	The scope template limits the amount of detail that can be included at this stage. Outcomes such as isolation and level of interaction will be considered if they are reported in the available evidence. Please see previous response about disadvantaged groups.
NIHR Nottingham Hearing Biomedical Research Unit	General		The current scoping document fails to recognize the role of hearing in cognitive and quality of life in older people. Hearing loss is currently estimated to be the 13th most common disease burden worldwide. By 2031, 14.5 million people in the UK will have hearing loss (Action on Hearing Loss Report, 2012) and the World Health Organisation predict that by 2030 adult onset hearing will be the 7th leading disease burdens in the UK, above diabetes and HIV. The wider consequences of hearing loss on the health and well being of older adults have become apparent from recent epidemiological studies (National Health and Nutritional Examination Survey; Health, Ageing and Body Composition Study, and Baltimore Longitudinal Study of Ageing). Evidence shows that hwearing loss is independently associated with poorer cognitive functioning , accelerated rates of brain atrophy as measured on MRI, greater cognitive decline and increased risk of developing dementia.	Thank you for your comment. The final scope will include hearing loss. Epidemiological studies and trials of midlife interventions in midlife will be considered for inclusion in the evidence reviews. The advisory group can make research recommendations in areas were evidence is lacking.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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			The impact of timely hearing rehabilitative interventions on delaying cognitive decline, and dementia in older adults may be highly significant. Such interventions require further research to inform clinical practice and shape NICE guidance. The focus on your guidance on adults aged 40 – 64 is entirely appropriate as this is the age group where the optimization of hearing will likely produce the most gains, especially in terms of enhancing cognitive capacity during ageing. We suggest that future evidence collection, including studies of economic impact, should embrace the question of hearing loss in the ageing population and their access to hearing care in the community. www.actiononhearingloss.org.uk/about-us/annual-report.aspx Lin FR et al hearing loss and incident dementia Arch Neurol 2011, Feb;68(2): 214-20 Lin FR et al hearing loss and cognition among older adults in the United States J. Gerontol, A Biol Sci med Sci 2011. Oct 66(10): 1131-6 Lin FR, hearing loss and cognitive decline in older adults, JAMA Intern Med 2013, Feb 25, 173 (4): 293-9Lin FR Hearing loss in older adults: who's listening? JAMA 2012, Mar 21; 307(11):1147-8 Yamasoba T et al Current concepts in age-related hearing loss: epidemiology and mechanistic pathways Hear Res 2013, Feb 16 (E pub ahead of print)	Thank you for your comment
Royal College of Nursing	General	General	The Royal College of Nursing welcomes proposals to develop this public health guidance. It is timely. The draft scope seems comprehensive	Thank you for your comment.
Royal College of Nursing	4.3	6	Is there a question to be asked regarding types of employment? Stress? etc.	Thank you for your comment.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
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				Where we are able to identify appropriate evidence, issues such as type of employment during midlife and its effect on later health will be reported in the evidence reviews (in particular, in review 1).
Royal College of Nursing	4.3	7	What about changes in level of recreational drug consumption?	Thank you for your comment. o keep the work within the time and resources available there is a need to limit the range of behaviours included
Royal College of Nursing	General	General	Need to consider the impact of loneliness and poor mental health on quality of life and wellbeing, along with interventions which support good mental health. Here are some relevant links to support: Dementia and loneliness - http://www.alzheimers.org.uk/dementia2013 Promoting mental health and well-being in later life (UK inquiry into Mental well being in later life) - http://www.nationalcareforum.co.uk/forums/forum_posts.asp?TID=1156&PN=1	Thank you for your comment. Participation in work and social activities is included in the scope. You may also be interested in a second referral from DH for guidance on 'Primary, secondary and tertiary interventions to promote mental well being and independence of older people' which we anticipate will address many of the issues that you raise. You can read more about this planned guidance here: http://guidance.nice.org.uk/PHG/65 , and we would encourage

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				your organisation to register as stakeholders for it.
The Royal College of Psychiatrists	General		How will the guidance relate to people with pre-existing cognitive impairment, for example, people with intellectual disabilities or acquired brain injury who are a great risk of disability and frailty? Will additional guidance be developed to consider the needs of these vulnerable groups of people?	Thank you for your comment. People in these groups will be covered by this guidance.
Royal national institute of blind people	2b	1	Definition of successful aging (and therefore scope of exercise) should include maintaining visual function and/or sensory health. The reasons are: **Vision is an important part of maintaining independence and quality of life in older age.** RNIB research reveals that people living with sight loss: • report having lower feelings of wellbeing • are more likely to experience financial hardship • face greater restrictions to their participation in education and employment • report that they have less choice about how they spend their free time, and that • Barriers remain to accessing travel, shopping and other activities[32]	Thank you for your comment. The final scope will include sight loss.
Royal national institute of blind people	2b	1	**Sight loss is linked to health–related behaviours and lifestyle factors:**	Thank you for this information. The final scope will include

[32] Sally McManus and Chris Lord, Natcen (2012) "Circumstances of People with Sight Loss" Natcen and RNIB.

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			• **Smoking** doubles the risk of developing age related macular degeneration (AMD) which is the leading cause of sight loss[33] The link between smoking and sight loss has also been shown to be a powerful incentive for individuals to stop smoking.[34] • **Diabetes** can lead to diabetic retinopathy - a sight threatening condition. Between 5 and 10 per cent of all diabetics develop the eye disease proliferative retinopathy. It is more common in people with type 1 diabetes than type 2. Sixty per cent of type 1 diabetics show some signs of proliferative disease after having diabetes for 30 years. People from a South Asian background have a higher risk of diabetes and hence diabetic retinopathy.	sight loss, and the Public Health Advisory Committee will consider evidence about variation in impact, delivery and effectiveness of interventions on different population sub groups as they develop the guidance.

[33] Evans, Fletcher and Wormald (2005): 28,000 cases of AMD causing visual loss in people aged 75 years and above in the United Kingdom may be attributable to smoking. British Journal of Ophthalmology 89 (2005) 550-553.

[34] Wilson, NA et al "Smoking and blindness advertisements are effective in stimulating calls to a national quitline". BMJ 328 (7439) (2003) 537-538, and Borland et al. "Impact of graphic and text warnings on cigarette packs: findings from four countries over five years", Tob Control 18 (2009) 358–64.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Regular eye screening (as part of the diabetic retinopathy screening scheme) and careful monitoring of blood glucose can help to prevent sight loss. • **Obesity** is also a factor in developing AMD and cataracts.[35] • **Healthy eating** has been associated with reduced incidence of AMD and cataract.[36] • **Lifetime exposure to UV light** has been shown to cause cataract and corneal damage[37] and has been linked to retinal damage and AMD.[38]	
Royal national institute of blind people	2b	1	**There is a link between non-communicable diseases which are affected by lifestyle factors and sight loss** **Dementia and sight loss**: Dementia and sight loss may each cause confusion or disorientation and lead to loss of independence, activities and social contact. Both conditions change and flexibility in response is essential. 750,000 people have dementia in the UK, most of whom are over 65 and around 1 in 7 of the over 65s is living with significant sight loss. By the age of	Thank you for this information.

[35] RNIB and Royal College of Ophthalmologists, 2010 "Understanding Cataracts" and "Understanding AMD" RNIB.
[36] Suzen M. Moeller, MS, Paul F. Jacques, DSc, and Jeffrey B. Blumberg, PhD, FACN, "The Potential Role of Dietary Xanthophylls in Cataract and Age-Related Macular Degeneration" in Journal of the American College of Nutrition, 19, No. 5, (2000) 522S–527S.
[37] J. ČEJKOV, et al, "UV Rays, the Prooxidant/Antioxidant Imbalance in the Cornea and Oxidative Eye Damage" Physiol. Res. 53 (2004) 1-10,
[38] RNIB and Royal College of Ophthalmologists, 2010 "Understanding Cataracts" and "Understanding AMD" RNIB.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			75 at least 2.5 per cent of people will have both conditions. As the population ages, the number of people with both dementia and sight loss will increase. In care homes, studies indicate a higher proportion of residents may have both conditions.[39] One condition may mask or be mistaken for the effects of the other and lead to inaction. For example sight loss may lead to disorientation and confusion and if this is attributed to dementia actions that can make the most of vision (such as improving lighting) may not be taken. Visual awareness training for staff working with people with dementia is useful. Information about sight loss, its causes and effects is helpful to family carers and friends. Dementia awareness training for staff working with older people with sight loss is useful. Information about dementia and its effects is helpful to family carers and friends.	
Royal national institute of blind people	2b	1	**There is a link between non-communicable diseases which are affected by lifestyle factors and sight loss:** • **Stroke and sight loss** - up to two thirds of people experience some changes to their vision after stroke.[40]	Thank you for this information. Sight loss will be included in the final scope, and where we can identify appropriate evidence the PHAC will consider the issues you raise as they develop the guidance.

[39] Dementia and Sight Loss Interest Group (2012) "Dementia and sight loss FAQs" Vision 2020.
[40] The Stroke Association (2012) "Visual problems after stroke"

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Once a person's vision impairment is assessed, the most effective treatment options can be deployed to minimise impact. Rowe, a leading researcher in the field, noted that: "often staff on stroke teams do not refer patients for vision assessment because of a common misperception that little can be done to treat visual impairment following stroke"[41]	
Royal national institute of blind people	2b	1	**Sight loss affects a growing number of people.** There are around two million people in the UK living with sight loss and that number is set to reach four million by 2015. Sight loss predominantly affects people over 65: the number of people with sight loss (eyesight worse than that necessary to drive) aged between 65-75 is estimated to be almost seven in one hundred people. This compares to the	Thank you for this information.

[41] F Rowe, "The importance of accurate visual assessment after stroke" Expert Rev. Ophthalmol. 6(2), (2011) 133–136

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			number of people with similar sight loss aged between 50-54 which is estimated to be 1.5 per cent.[42]	
Royal national institute of blind people	2b	1	**There is a link between sight loss and debilitating falls in older age.** There is a high correlation between sight loss and falls. The Blue Mountains Eye Study concluded that visual impairment is strongly associated with two or more falls in older adults.[43] It was also suggested that in addition to poor visual acuity, visual factors such as reduced visual field, impaired contrast sensitivity, and the presence of cataract could also explain this association. We would also note that while visual impairment has been listed as a one of the seven main risk factors in falls, studies emphasise how reduced vision either from normal ageing or specific eye conditions are linked to the other seven risk categories. For example, impaired vision has been shown to adversely affect postural stability and increase the risk of falling in older people (Lord: 2006).[44]	Thank you for this information.
Royal national institute of blind people	4.21 b	6	**People with sight loss should be targeted as a "disadvantaged group" for interventions** As a demographic, people with sight loss are unable to access public health	Thank you for your comment

[42] Access Economics (2009) "Future Sight Loss 1" : RNIB.
[43] Ivers RQ, Cumming RG, Mitchell P, Attebo K (1998) "Visual impairment and falls in older adults: the Blue Mountains Eye Study" Source: Department of Public Health and Community Medicine, University of Sydney, New South Wales, Australia.

[44] Lord, S, "Visual risk factors for falls in older people" in Age and Ageing , 35 (S2), (2006) ii 42-ii45.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			messaging displayed on billboards, TV ads, packaging etc. They also experience additional barriers to healthy living behaviours - for example, difficulty participating in exercise classes, running or going for walks (without a guide) or difficulty self screening moles for cancer. In addition, there are challenges in relation to eating healthily, often people with poor vision use readymade meals and ready-cut vegetables rather than risk injury in cutting vegetables themselves. In addition, people with sight loss who fall into further ill health in older age are then faced with multiple disabilities in later life which has a massive impact on their independence.[45]	
Royal national institute of blind people	Appendix B	12	The draft scope suggests that social models of disability will be considered. As such: **the role of rehabilitation in regaining independence after sight loss [disability] should be considered.** Rehabilitation can mean that a person regains independence after sight loss; that they can find their way around their town; that they gain confidence and motivation to stay involved in society: all wider determinants of health. As there is a link between sight loss and other disabling conditions, which can be affected by lifestyle factors, there is the opportunity to decrease or avoid the effect of multiple disabling conditions through rehabilitation at an early stage.[46]	Thank you for your comment. The role of rehabilitation after sight loss is beyond the referral from the DH. Please see Appendix A of the scope.

[45] S Cooper (2013) 'As Life Goes On' Thomas Pocklington Trust.
[46] See above re: dementia, diabetes and stroke.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Considering rehabilitation is particularly important, and as local authority budgets are under strain, there is a need to resource this service.[47]	
Royal national institute of blind people	General		**On equality impact:** social economic factors affect eye health. The perceived orientation of optometry towards the sale of glasses encourages people to view eye examinations as different from other primary health prevention and uptake is lower among people with lower incomes.[48]	Thank you for your comment. The PHAC will consider all relevant equity issues as they develop the guidance, and NICE will also complete an equity impact assessment of this guidance.
Royal national institute of blind people	4.12	5	**We strongly recommend that the scope be widened to include interventions to maintain health for those people affected by conditions which develop in middle age and are not preventable (such as glaucoma) but for which the disabling effects are preventable.** Approximately 10 per cent of UK blindness registrations are attributed to glaucoma. The overall prevalence of glaucoma is around 2 per cent of people over 40. The prevalence rate increases with age and is estimated to rise to almost 10 per cent in people over 75. **On equality**: people from Black and Minority Ethnic communities tend to experience higher levels of unnecessary sight loss. People from African and	Thank you for your comment. It is necessary to keep the work within the remit of the referral from the DH, which asks us to focus on modifiable risk factors. For further information on how to refer topics for consideration for future guidance production please see http://www.nice.org.uk/getinvolved/topicselection/topicselection.jsp

[47] Alison Binns, Catey Bunce, et al. 2009 "Low vision service outcomes: a systematic review ": RNIB see also Tammy Boyce (2011) "Innovation and quality in sight loss and blindness services: Eye Clinic Liaison Officers": RNIB.

[48] Carol Hayden et al (2012) "Access to Primary and Secondary Eyecare" RNIB and Shared Intelligence. For interventions see Johnson, (2012) "A review of evidence to evaluate effectiveness of intervention strategies to address inequalities in eye health care" RNIB and De Monfort.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			African/Caribbean backgrounds have a six times increased risk of developing glaucoma and develop it at an earlier age than people from other ethnic groups. Late presentation with glaucoma contributes significantly to outcomes in terms of the amount of sight that can be saved. Late presentation of sight-threatening disease in these groups is linked partly to cultural factors (only 38 per cent of Africans and African/Caribbeans aged over 60 have regular eye tests against 66 per cent of the general population).	
Royal national institute of blind people	4.12	5	**The age range of 40-65 should be expanded to include those people whose sight can be improved after the age of 65 for example simply by recommending having regular sight tests.** This is recommended because there is anecdotal evidence of significant under diagnosis of preventable sight loss in older people. Almost two thirds of sight loss in older people is caused by refractive error and cataract. Both conditions can be diagnosed by a simple eye test. In most cases the person's sight could be improved by prescribing correct glasses or cataract surgery. As it is already established that sight loss is a key factor in remaining independent we recommend that eye screening be considered.[49]	Thank you for your comment. It is necessary to keep the work within the remit of the referral from the DH.
Social care Institute for Excellence (SCIE)	General		The impact of the guidance might be better supported by a rationale for identifying the 3 issues of disability, dementia and frailty. They have different aetiologies and other conditions of older age may also be conducive to mid-life approaches to prevention.	Thank you for your comment. The three issues are from the referral from the Department of Health. Please see Appendix A in the scope.
Social care Institute for Excellence (SCIE)	General		The complicating factors of mental health, social isolation and the link between	Thank you for your comment. Hearing and visual loss will be

[49] For interventions see, Johnson, (2012) "A review of evidence to evaluate effectiveness of intervention strategies to address inequalities in eye health care" RNIB and De Monfort.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			deafness and dementia are not mentioned and are likely to be relevant to preventative interventions.	included in the final scope.
Social care Institute for Excellence (SCIE)	General		The scope is health orientated which could mean a focus on individual conditions and behaviours only. Wider solutions including the regulatory responsibilities of the local authority (eg environmental health, trading standards) and local wellbeing initiatives might be useful to consider.	Thank you for your comment. To keep the work manageable within the resources available it is not possible to address all perspectives. There is a range of NICE guidance that covers the main environmental issues.
Social care Institute for Excellence (SCIE)	General		Equality of opportunity. The guidance is to exclude adults with any type of dementia or pre-existing cognitive impairment. But given the increasing numbers of people with multiple co-morbidities, this may limit the impact of the guidance. It may be important that a person with dementia benefits from a change in health behaviours if it lessens the risk of frailty or other disability developing. This is particularly relevant in terms of costs. A particular focus on ethnicity may also be valuable, since there are health conditions which affect certain ethnic groups more than others. Some focus on the experiences of older LGBT people would help to inform health prevention messages. They will form a proportion of older people with the 3 issues and may be less well supported than heterosexuals by social networks or by care services.	Thank you for your comment. The scope only excludes people with a condition or disability from interventions to prevent that condition or disability. The referral from the DH is for approaches to be adopted in mid-life. Focusing on older people is outside of the remit of this referral.
Social care Institute for Excellence (SCIE)	2 d	2	Age range: this seems appropriate for these conditions although ages within the range may have different attitudes and perspectives, requiring different messages.	Thank you for your comment.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Age Action Alliance, of which SCIE is a member, has a working group for public health matters and would be a useful contact for this guide development.	
Social care Institute for Excellence (SCIE)	3 e	4	An understanding of why and how different socio-economic groups have responded provides useful evidence for intervention and health promotion.	Thank you for your comment.
Social care Institute for Excellence (SCIE)	4.3	6-8	It may not be possible to identify evidence that specifically links health related behaviours to the development of disability, dementia and frailty. Factors in the development of dementia in particular are not well understood and are likely to be various.	Thank you for your comment.
Sense	3 d	4	Sense is concerned that social isolation and loneliness are omitted from the seven health risk factors and urges NICE to include it. The White Paper published in 2010, 'Healthy Lives, Healthy People', recognised the adverse impact on health of social isolation and loneliness and the health benefits of promoting social inclusion and reducing isolation and loneliness. Research by the Campaign to End Loneliness (of which Sense is a managing partner) shows that feeling lonely is as bad for health as smoking 15 cigarettes a day (1). Other research shows that isolation and loneliness • Increases the risk of heart disease (2) • Increases the risk of hypertension (3) • Is associated with higher levels of depression (4) • Is linked with increased cognitive decline and dementia ((5, 6) • Is a predictor of theonset of disability, especially for men (7)	Thank you for your comment. We recognise the importance of social isolation and consequently included participation in the examples of outcomes of interest. . In addition, you may be interested in another public health referral that also been received from DH for guidance on 'Primary, secondary and tertiary interventions to promote mental well being and

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Therefore, social isolation and loneliness should not be overlooked. The guidance should include recommendations to promote social connectedness. This is a particularly important issue for deafblind people. Deafblindness is a combination of both sight and hearing difficulties. Most of what we learn about the world comes through our ears and eyes, so deafblind people can often face problems with communication, access to information and mobility. Consequently, many deafblind people are socially isolated and lonely and experience worsening physical and mental health as a result. References 1. Holt-Lunstad J, Smith TB, Layton JB. (2010) Social relationships and mortality risk: a meta-analytic review. PLoS Med 2010;7(7) http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.100031 2. Ong AD, Rothstein JD, Uchino B (2012) Loneliness Accentuates Age Differences in Cardiovascular Responses to Social Evaluative Threat. Psychology and Ageing 27 (1). http://www.ncbi.nlm.nih.gov/pubmed/ 3. Hawkley LC, Thisted RA, Masi CM, Cacioppo JT (2010) Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. Psychol Aging 25(1) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841310/ 4. Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. Psychol Aging 21(1) http://www.ncbi.nlm.nih.gov/pubmed/16594799	independence of older people' which we anticipate will address many of the issues that you raise. You can read more about this planned guidance here: http://guidance.nice.org.uk/PHG/65 , and we would encourage your organisation to register as stakeholders for it.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			5. James BD, Wilson RS, Barnes LL, Bennett DA (2011). Late-life social activity and cognitive decline in old age. J Int Neuropsychol Soc 17(6) http://archpsyc.jamanetwork.com/article.aspx?doi=10.1001/archpsyc.64.2.234 6. Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. (2007) Loneliness and risk of Alzheimer disease. Arch Gen Psychiatry 64(2) http://www.ncbi.nlm.nih.gov/pubmed/17283291 7. Lund R, Nilsson CJ, Avlund K. (2010) Can the higher risk of disability onset among older people who live alone be alleviated by strong social relations? A longitudinal study of non-disabled men and women. Age Ageing 39(3) http://ageing.oxfordjournals.org/content/39/3/319.long	
Sense	3 f	4	The health benefits of social connectedness must be recognised in the guidance. Deafblind people are often socially isolated and lonely and experience worsening physical and mental health as a result. This can be helped by the provision of appropriate social care services.	Please see previous response.
Sense	4.1.1	5	Sense welcomes the recognition that the guidance should apply to younger adults from disadvantaged groups. We urge NICE to consider the disadvantage experienced by deafblind people. Risk factors that are particularly prevalent amongst deafblind people include • Social isolation • Loneliness • Sedentary lifestyles due to being unable to get out and about without support from another person • Poor diet due to difficulties shopping regularly for fresh healthy food	Please see previous response.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			and/or difficulties cooking • Lack of access to information about healthy living • Being on a low income.	
Sense	4.2.1	5	For deafblind people, interventions to promote healthy lifestyles must address the individual's needs for communication, mobility and access to information. Sense welcomes the recognition of the importance of interventions to increase physical activity and improve diet. For deafblind people, provision of appropriate social care is often critical to them being able to be active and eat healthily. For example, many deafblind people need a communicator-guide or intervenor (people specially trained to provide support with communication, mobility and access to information to deafblind people) in order to be able to get out to take exercise or to be able to shop for fruit and vegetables. A deafblind person may understand the importance of physical activity and healthy living, and want to lead a healthy lifestyle, but be unable to do so without appropriate one-to-one support.	Please see previous response.
South West Yorkshire Partnership NHS Foundation Trust	2 Background (c)	1/2	Related Policies:Long Term Conditions	Thank you for your comment. The scope template limits the amount of information that can be included.
South West Yorkshire Partnership NHS Foundation Trust	4.3 Outcomes	7	Very woolly about Outcomes – needs to be related to the various outcome frameworks and metrics within the whole of the health services.	Thank you for your comment. The scope template limits the amount of information that can be included. The aim in this

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				section is to give a broad overview of the type of outcomes of which are of interest.
The British Psychological Society	General		The Society welcomes the intention to produce public health guidance to reduce the likelihood of developing disability, dementia and frailty. An important consideration will be to ensure a balance of focus between individual lifestyle change and broader socio-economic and cultural influences on the outcomes in question.	Thank you for your comment.
The British Psychological Society	General		The Society recommends that the scope includes greater reference to the demographic factors that impact on behaviour and the ability to change behaviour. For example, women are more likely to be carers than men.	Thank you for your comment. The scope template limits the amount of information that can be included. Social and demographic factors, alongside other issues where variations in health or inequities are observed, will be considered by the Public Health Advisory Committee as they develop the guidance.
The British Psychological Society	General		The Society believes that geographical location should be considered in the guidance as this is an important factor in behaviour change and intervention delivery. For example, in rural communities, internet interventions may be better than face-to-face interventions. Similarly, rural farming communities may already be physically active because of their job. But may need psychological intervention to change beliefs towards other unhealthy behaviours such as alcohol use. Online interventions could use goal setting as one way of changing and monitoring behaviour in rural communities.	Please see previous response.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Psychological Society	Section 1.1, point 2.a	1	There is evidence that behavioural patterns are established early on in life therefore to focus on mid life and an age definition of 40-64 seems unnecessarily restrictive; especially as the numerical years lived do not correlate well with the aging process. The guidance would need to ensure that there is continuity with other policies/ guidance across the lifespan and needs to take into consideration the differences across the devolved nations in health and social care provision, economic status etc.	Thank you for your comment. The referral from the DH focuses on midlife. We acknowledge that early life also has an influence but to keep the work manageable within the resources available it is necessary to limit the age range. NICE has previously published public health guidance on relevant risk factors, children and young people – for a full list of published guidance and guidance in development, see here: http://www.nice.org.uk/guidance/phg/index.jsp
The British Psychological Society	Section 1.1, point 2.b	1	The concept of "independence" needs to be defined carefully since we all are dependent on others and that learning to accept help and assistance is one of the main challenges of aging. It may be that a focus on inter-dependence is more helpful, or concepts of locus of control and wellbeing. Re-framing the stereotypes that exist around older people and moving away from portrayals of older people as a "drain" on the economy and resource would be a helpful step to more tolerant, respectful community.	Thank you for your comment.
The British Psychological Society	Section 1.1, point 3.b	3	Although we understand that the guidance will focus on providing guidance for preventative interventions, we believe that it will be important to do ensure this takes account of the wider context of societal determinants such as views on aging, policies on retirement age and available care provision for elderly	Thank you for your comment. We acknowledge that these are important issues however, it is necessary to restrict the scope

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			relatives.	so it is manageable within the time and resources available. Future guidance on older people in the workplace is planned. (please see http://www.nice.org.uk/guidance/phg/indevelopment/index.jsp?p=off)
The British Psychological Society	Section 1.1, point 3.d	4	The document offers a very biomedical perspective on health. The Society suggests consideration of evidence relating to psycho-social factors and health, for instance stress and loneliness. Although perhaps harder to quantify the effects on health, factors also need to be addressed if the aim is to reduce onset of dementia and ill-health in later life. There is no mention of depression and yet that is thought to be a widespread problem affecting a relatively significant proportion of adults, and is associated with poor self-care and limited participation in cognitively and emotionally enriching activities.	Thank you for your comment. Participation in work and social activities is included in the scope, and where evidence is available, review 1 will consider the wider correlates of dementia, disability and frailty in mid-life.
The British Psychological Society	Section 1.1, point 3.e	4	The fact that the biggest reduction in the number of people displaying life style risk behaviours is amongst people in higher socioeconomic and educated groups, might well indicate to societal factors that we know influence physical and mental health need to be the focus of the guidance.	Thank you for your comment. The Public Health Advisory Committee will consider these types of issues in the development of the guidance.
The British Psychological Society	Section 4.1.2	5	Although it is appreciated that restrictions are needed for the purpose of this guidance, it is those with already existing health conditions who are at greater risk of developing other co-morbidities, leading to frailty, disability and dementia. It is the ability to comply with treatments and suggested changes in life style that might have contributed to the emerging difficulties in the first place.	Thank you for your comment. The advisory group will consider these types of issues in the development of the guidance.
The British Psychological	Section 4.1.2	5	This opening statement seems to locate the problem exclusively within the	Thank you for your comment.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Society			individual's behaviour, and neglects the multiplicity of variables (ranging from genetic to socio-economic) involved in the aetiology of most conditions For example, even diabetes Type 2 is not 'simply' a function of being overweight as many overweight people are not diabetic. The statement is also using the word 'disability' to mean disease or impairment and entirely neglects the social model of disability perspective which regards disability as created by social and attitudinal barriers, and different from impairment. The Society is concerned at the way in which the population of middle aged people seems to be divided conceptually into healthy and ill, and by implication deserving or undeserving of support to maintain health/well-being. Large numbers of people in middle age are affected by arthritis for example – and may well benefit from advice about how to maintain activity in their lives.	The definition of disability is based on ICIDH-2 and acknowledges the role of other factors such as the environment; however the scope does not address these as there is existing NICE guidance on the environment in relation physical activity, diet, smoking and alcohol, CVD and diabetes prevention. – you can access a full list of published NICE public health guidance here: http://www.nice.org.uk/guidance/phg/index.jsp
The British Psychological Society	Section 4.2.1, point c	6	We realise that this is the scope for the developmet of the guidance and therefore the language used is necessarily vague. However, any resulting guidance will need to acknowledge the impact of language in marginalising and discriminating those with unhealthy lifestyles which can impact on their motivation to change.	Thank you for your comment. The guidance development will follow standard NICE procedures on equity and equity assessment: You can read about them in the current Centre for Public Health methods and process guides: http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/publichealthguidanceprocessandmethodguides/public_health_guidance_pro

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				cess_and_method_guides.jsp
The British Psychological Society	Section 4.2.1, point c	6	Due to proposed target age group, we suggest that there should be more focus on interventions at work. If working environments were focussed on for delivering behaviour change interventions this may help this age group adopt preventive behaviours	Thank you for your comment. We acknowledge that the workplace will be important. There are 3 other pieces of guidance in development focusing on workplace health (please see http://www.nice.org.uk/guidance/phg/indevelopment/index.jsp?p=off) It will be necessary to avoid unnecessary overlap with these.
The British Psychological Society	Section 4.3, question 3	7	The multiple demands on individuals aged 40-64 needs to be acknowledged. For example; their own elderly parents, their own young or teenage children, pets. In addition to this, this age range also tend to be working, many of whom may be moving up the career ladder. Therefore, some individuals may have little time to spend undertaking and maintaining their own healthy behaviours as they are 'juggling' many things, so their own health becomes less of a priority.	Thank you for your comment. We would prefer not to anticipate the outcome of the evidence reviews in the scope but age-specific issues will be considered as outlined in question 3.
The Lesbian & Gay Foundation	General		The guidance needs to make clear that disadvantaged groups are not one homogenous group, but include equality groups that may experience further disadvantage, for example lesbian, gay, bisexual and trans (LGB&T) people. The focus on ethnicity, gender and socio-economic status is too restrictive. Other equality groups should be referenced in the guidance so that their inclusion is explicit. The guidance needs to explain that these equality groups are made up of different protected characteristics that may experience	Thank you for your comment. The groups in the scope are given as examples. Exploration of subgroups will be directed by the evidence.

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			multiple-disadvantage.	
The Lesbian & Gay Foundation	3	3	The health risks presented all relates to the general population, and does not take account of the evidence relating to health inequalities experienced by protected characteristic groups, e.g. LGB&T people. A body of evidence shows higher incidence of smoking, alcohol and drug use, and eating disorders among LGB&T communities, all of which relate to the need for guidance as presented in section 3.	Thank you for your comment. The groups in the scope are given as examples. NICE has clear procedures for dealing with equality issues, please see the NICE revised equality scheme and the CPH methods manual for further details.
The Lesbian & Gay Foundation	4.1.1	5	This section mentions disadvantaged groups, but there is no definition of this given in the document. A definition of disadvantaged groups needs to include those with protected characteristics, such as LGB&T people who may have lower life expectancy than the general population. Little research has been conducted into life expectancy among LGB&T communities, however a body of evidence shows higher incidence of smoking, alcohol and drug use, and eating disorders, all of which would lead to lower life expectancy.	Please see previous response
The Lesbian & Gay Foundation	4.2.1	5-6	The definition of disadvantaged groups needs to include equality groups, such as LGB&T people, who may be more at risk of these conditions in later life. The guidance needs to make clearer that disadvantaged groups will include communities of identity (such as LGB&T communities) as well as geographic communities. Targeted interventions will result in improved outcomes, but the evidence base needs to be understood in order to support such interventions. Interventions delivered by the voluntary sector will be essential to reducing risk.	Please see previous response.
The Lesbian & Gay Foundation	4.3	7-8	The Expected Outcomes should also measure isolation and level of interaction with someone's community, which may not be geographically focused. For example, fear of travel or leaving one's home may impact on a person's	Thank you for your comment. The scope includes participation in work and social activities as

Public Health Guidance

Delaying the onset of disability, frailty and dementia in later life - Consultation on Draft Scope
Stakeholder Comments Table

21st March 2013 – 18th April 2013

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			mental health and physical health. The outcomes should also measure improvements by equality group, achieved through monitoring protected characteristics such as the sexual orientation and gender identity of patients. This will ensure that health inequalities between groups are reduced, as well as the health of the overall population improved.	examples of this type of outcome. Where data is available outcomes will be reported by subgroups.
The Vegan Society	General		Undiagnosed vitamin B12 deficiency is a major contributor to mental issues in later life. NICE should urgently examine recommendations that everyone over the age of 50 (no matter their diet etc.) should get vitamin B12 first-hand from supplements or fortified foods, and the peer-reviewed evidence which supports this. Vitamin B12 supplements represent an extremely cost-effective way to address a common cause of mental incapacity.	Thank you for your comment. The final scope will focus on the impact of behavioural risk factors on later disability, dementia and frailty, and will not include dietary supplements For information about how to propose a new guidance topic to NICE, see http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/PublicHealthTopicSelection.jsp
The Vegan Society	General		Diverse and well-founded evidence is accumulating about the benefits of well-planned plant-based diets to support long healthy life expectancy. NICE should examine the real potential of affordable plant-based catering in all health settings, to support good outcomes for all involved (no matter their status, patient or non-patient, nor their dietary ethics).	Thank you for your comment. Where evidence is identified about the impact of dietary behaviour on later disability, dementia or frailty, it will be considered by the public health advisory committee as they develop the guidance.