Public Health Guidelines

DISABILITY, DEMENTIA AND FRAILTY IN LATER LIFE – MID-LIFE APPROACHES TO PREVENTION- Consultation on Draft Guideline Stakeholder Comments Table

14 July 2014 – 5 September 2014

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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	15.0	General		Action on Hearing Loss welcomes the opportunity to submit evidence for the 'Disability, Dementia and Frailty in Later Life- Mid-life approaches to prevention' public health guidance. As the largest UK charity working for people with hearing loss, including researching, campaigning and providing services, Action on Hearing Loss would like to offer our expertise and support in developing this guidance. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to be made public.	Thank you for your comments.
Action on Hearing Loss	1.0	1. Draft recommendations	pp.4-14	We are concerned by the very limited acknowledgment of the role hearing plays in cognitive well-being in these recommendations. Healthy ageing depends to a large extent on an individual's ability to communicate with those around them and to take part in social activities. Ten million people in the UK have a hearing loss. 71% of people aged over 70 have hearing loss, but many have not accessed hearing aids or other support to effectively manage their condition. Unaddressed hearing loss poses a threat to communication and increases the risk of social isolation[1]. Hearing loss is also	Thank you for your comment. The scope for this guideline does acknowledge the importance of hearing in cognitive wellbeing. This guideline focuses on interventions in mid-life (before the onset of age-related conditions), to delay or prevent dementia,

[1] Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional
distress and social engagement restrictions five years later. Age and Ageing 41(5): 618–623; National
Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head &

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				independently associated with dementia, with mild hearing loss doubling the risk of a person developing dementia, moderate hearing loss tripling the risk and severe hearing loss increasing the risk by five times. The attributable risk of dementia associated with hearing impairment is estimated to be 36%.[2] There is also a significant association between hearing loss and falls.[3] If it is managed effectively, the negative impacts of hearing loss can be greatly reduced. However, uptake rates of hearing aids (typically the best intervention for hearing loss) are extremely low. Six million people in the UK could benefit from hearing aids but currently only two million people have accessed them. On average, people referred for hearing assessment are in their mid-70s and have experienced auditory deprivation for 10 years or more[4]. By the time many people seek treatment, their ability to adapt and benefit from a hearing aid is greatly reduced. Earlier intervention would ensure that people are supported to manage their hearing loss at an age when they are most able to benefit. It is vital that once people are fitted with hearing aids, they are	disability and frailty. We did search for published evidence on this in relation to hearing and hearing loss when developing the evidence review, but found very little. We then sought expert testimony on mid-life interventions to prevent later hearing loss, and this was considered by the Public Health Advisory Committee (see Expert paper 10.) The final guideline represents what the PHAC felt they were able recommend on the basis of the available evidence. A research recommendation is made in this area.

Neck Nursing. 18(1): 12-6

[2] Lin et al. (2011) Hearing loss and incident dementia. Archives of Neurology 68 (2): 214-220

[3] Lin & Ferrucci (2012) Hearing Loss and Falls Among Older Adults in the United States.
Arch Intern Med. 172(4):369-371

[4] Action on Hearing Loss 'Hearing Matters' 2011

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				provided with the follow-up and support that they require to gain full benefit from hearing aids. Of the two million people in the UK who have already accessed hearing aids, only 1.4 million people regularly use their aids[5]. Ensuring that everyone who is fitted with hearing aids is supported to properly maintain and operate their aids would increase the usage rate. There is currently only one brief mention of hearing loss in these recommendations (under Recommendation 9). Given the strong evidence connecting hearing loss with increased risk of cognitive decline and social isolation, and the impacts that unaddressed hearing loss has on communication, we propose that a recommendation should be developed to protect hearing health and to effectively manage hearing loss as it develops. In addition, maintaining hearing health and managing hearing loss should be included as objectives within the following recommendations: - Recommendation 1: Develop and enforce policies and legal and regulatory frameworks to make it easier for people to protect their hearing and address a hearing loss - Recommendation 2: Include risk reduction for dementia, disability and frailty in national policy documents aimed at preventing other non-communicable chronic diseases (for example hearing loss)	

[5] NHS Choices Website. www.nhs.uk/Conditions/Hearing-impairment/Pages/Treatment. Accessed June 2013.

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				- Recommendation 7: Encourage and support healthy living, for example encourage and support people to protect their hearing and address a hearing loss - Recommendation 8: Commission national campaigns to encourage people to protect their hearing and to take action to address a hearing loss - Recommendation 11: Provide services to help people effectively manage their hearing loss - Recommendation 15: Train staff to identify and communicate with people with hearing loss, who are at an increased risk of dementia, disability or frailty - Recommendation 16: Provide information in the workplace to support employees to protect and check their hearing, and to address a hearing loss	
Action on Hearing Loss	3.0	3.Context	16	It is very positive to see the recognition in this section of the impacts and prevalence of hearing loss.	Thank you for your comment.
Action on Hearing Loss	4.2	4.2 Considerations	19	We agree that the risk of developing dementia, disability and frailty can be reduced through changing common behavioural risk factors. Protecting hearing health and taking action to address a hearing loss should be included in this section. Key messages about risk reduction relating to hearing are poorly publicised and are not well understood by most health and social care professionals.	Thank you for your comment. The considerations section outlines the rationale and process of making recommendations, and records some of the issues that arose during that process. Recommendations are not included in this

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					section.
Action on Hearing Loss	4.6	4.6 Considerations	20	We agree that putting polices and services in place to encourage change in relevant behaviours could have huge benefits for individuals, families and the population as a whole. One behaviour change that is much-needed is action to address adult-onset hearing loss. On average older people do not take action to effectively manage their hearing loss for a decade. Unaddressed hearing loss 'gives rise to disabilities of various kinds'[6], increasing the risk of mental health problems[7] and social isolation[8], and reducing people's independence[9] and their ability to manage other health conditions.[10]	Thank you for your comment. We did search for published evidence on this in relation to hearing and hearing loss when developing the evidence review, but found very little. We then sought expert testimony on mid-life interventions to prevent later hearing loss, and this was

[6] Arlinger (2003) Negative consequences of uncorrected hearing loss – a review. *International Journal of Audiology*, 42(2): 17-20

[7] Eastwood, M. R., Corbin, S. L., Reed, M., et al (1985) Acquired hearing loss and psychiatric illness: an estimate of prevalence and co-morbidity in a geriatric setting. *British Journal of Psychiatry*, 147, 552–556; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. *Journal of the American Geriatrics Society* 58, 1, 93-7; National Council on Aging (2000). The consequences of untreated hearing loss in older persons. *Head and Neck Nursing*, 18(1), 12-6; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. *Gerontology* 45:323-323

[8] Herbst KRG, Meredith R, Stephens SDG. Implications of hearing impairment for elderly people in London and in Wales. *Acta Oto-laryngologica*. 1990;476:209-214; Du Feu, M. and Fergusson, K. (2003) Sensory impairment and mental health, *Advances in psychiatric treatment*, 9:95-103.

[9] Keller et al (1999) The effect of visual and hearing impairments on functional status. *Journal of American Geriatric Society.* 47(11):1319-25.

[10] DCAL and Action on Hearing Loss (2013). Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions. Available at www.ucl.ac.uk/dcal/documents/Joining_Up_long_term_conditions_report.pdf (Accessed July 2014)

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				It is therefore extremely important that policies and services are put in place to encourage people both to protect hearing health (to prevent hearing loss) and to address hearing loss as soon as it occurs.	considered by the Public Health Advisory Committee (see Expert paper 10.) The final guideline represents what the PHAC felt they were able recommend on the basis of the available evidence. A research recommendation (5.4) is made in this area.
Action on Hearing Loss	4.10	4.10 Considerations	21	We welcome the recommendation that interventions and services should be accessible to the whole community. People with hearing loss have a range of accessibility needs. For example, for people who use British Sign Language (BSL) as a first language, English is often a second language and access to written English can be challenging. Any written information should therefore be produced in accessible, plain English, accompanied by a visual representation of the key messages. These and other accessibility needs of people with hearing loss should be recognised and met in public health interventions: - All staff working on public health services and campaigns should be trained in deaf awareness and communication tips. - Assistive technologies (e.g. loop systems) and communication support (e.g. BSL interpreters and lipspeakers) should be provided, along with a range of methods for contacting the service (including email, textphone and SMS) - Videos with BSL translation and subtitles should be used to convey	Thank you for your comment. Recommendation 3 in the final guideline includes providing information via a range of media and formats.

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				key information on health advice websites.	
Action on Hearing Loss	4.20	4.20 Evidence	23	A growing body of evidence has identified a strong association between all levels of hearing loss and cognitive decline and dementia[11]. Recent research found that hearing loss not only increases the risk of the onset of dementia, but also accelerates the rate of cognitive decline.[12] Hearing aids may protect against and reduce the severity of cognitive impairment and disability.[13] There is also substantial evidence that hearing loss is linked to	We did search for published evidence on this in relation to hearing and hearing loss when developing the evidence review, but found very little. We then sought expert testimony on mid-life

[11] Lin et al. (2011) Hearing loss and incident dementia. Archives of Neurology 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. Internal Medicine 173(4): 293-299; Lindenberger and Baltes (1994) Sensory functioning and intelligence in old age: a strong connection. Psychology and Aging. 9: 339-355; Lindenberger and Baltes (1997) Intellectual functioning in old and very old age: cross-sectional results from the Berlin aging study. Psychology and Aging. 12: 410-432; Uhlmann et al (1989) Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. Journal of the American Medical Association 261: 1916-1919; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology & Neurotology 35(5): 775-81; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45: 323-323

[12] Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology & Neurotology 35(5): 775-81

[13] Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45:323-323; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people-.Arch Gerontol Geriatr. 52(3):250-2; Magalhães & Iório (2011) Evaluation of participation restriction and cognitive processes in the elderly before and after the audiologic rehabilitation. Jornal da Sociedade Brasileira de Fonoaudiologia, 23(1):51-56; Palmer et al (1999) Reduction in caregiver-identified problem behaviors in patients with Alzheimer disease post-hearing-aid fitting. Journal of Speech, Language & Hearing Research, 42(2):312-328; MacDonald et al (2012) The Effect of Hearing Augmentation on Cognitive Assessment Scales at Admission to Hospital. The American Journal of Geriatric Psychiatry, 20(4):355-361; Hutchison et al (2012) Presbycusis, part 1: can you hear the music of life? Care Management Journals, 13(3):148-172

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				increased risk of falls, which researchers suggest could be reduced by ensuring auditory information is available[14]. In one study, a 25-dB hearing loss was associated with a nearly threefold increased odds of reporting a fall over the preceding year.	interventions to prevent later hearing loss, and this was considered by the Public Health Advisory Committee (see Expert paper 10.) The final guideline represents what the PHAC felt they were able recommend on the basis of the available evidence. A research recommendation (5.4) is made in this area.
Action on Hearing Loss	4.30	4.30 Evidence	26	A hearing check should be included in the NHS Health Check programme and health and social care professionals should also incorporate hearing checks into other routine health checks and consultations for other conditions.	Thank you for your comment. The literature searches found no evidence on the impact of hearing tests. The Public Health Advisory Committee (PHAC) discussed the NHS Health Check as a vehicle for delivering a number of relevant checks and tests,

[14] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371; Viljanen et al (2009) Hearing as a predictor of falls and postural balance in older female twins. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 64(2): 312-7

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					including hearing and vision checks. The Expert Scientific and Advisory Panel for NHS Health Check has a developed a content review process that would have to be followed. Amending or introducing new content may require the approval of the government.
Action on Hearing Loss	5.0	5. Recommendations for research	27	There is a need for robust longitudinal evidence to further explore the link between hearing loss and cognitive decline, and in particular long-term evidence to prove the role that hearing aids play in preventing the onset or deceleration of cognitive decline.	Thank you for your comment. There was a lack of published evidence on the link between hearing loss and cognitive decline, and although the PHAC received expert testimony in this area, it was also not conclusive. The PHAC have therefore included a research recommendation (5.4) in the final guideline about hearing loss.
Action on Hearing Loss	6.0	6. Related NICE guidance	29	We suggest that the following NICE guidance should be included in this list: - Mental well-being: older people in care homes Quality Standard	Thank your comment. We do not include Quality Standards in the list of NICE guidelines. Links between

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				- Social care of older people with multiple long-term conditions - Hearing loss Quality Standard (under development)	recommendations and NICE quality standards sit in the NICE pathways, visual representations of recommendations in key topic areas.
Age UK	15.0	General		Age UK welcomes this public health guideline as a highly positive contribution to improving prevention of conditions common in later life. In particular, frailty has historically been under-recognised as both a distinct health state and something which it is possible to prevent, minimise and/or manage in older people. It should be a key measure of success for this guideline that frailty is mainstreamed as a preventable and better understood health state.	Thank you for your comment.
Age UK	15.0	General		We would also recommend that a further measure of success should be the extent to which all of these issues are mainstreamed in public health messaging. Risks of cancer, heart disease and early mortality are well known amongst the public, though not necessarily always acted upon. Public health messaging that equally promotes the needs and benefits of remaining active alongside increasing longevity is a crucial component of maintaining a healthy and productive ageing population. This is massively under-promoted as a preventative health outcome and we hope this guidance can make a significant difference. Frailty should become less thought of as an inevitable part of ageing and instead be seen as an avoidable, or very short-term, health state wherever possible.	Thank you for your comment.
Age UK	1.2	1	4	We would not seek to diminish the negative health impact of drinking	Thank you for your comment.

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				alcohol, particularly in harmful quantities. However, regarding recommendation 1 (make "alcohol less accessible, affordable and acceptable") we believe that in addition, stakeholders should seek to understand what impact this recommendation might have in terms of reduced accessibility to local facilities/ activities that older people rely on for social interaction. For example, social settings such as pubs and sports clubs can protect against loneliness. Evidence increasingly shows the negative health impact of loneliness, with one study suggesting it is equivalent to 15 cigarettes a day and some older people may rely on such settings to socialise where they otherwise have very little human contact. Efforts to reduce alcohol consumption must include support for local communities to find alternative activities rather than, in isolation, restricting opportunities to drink. There is a vital need to promote and support healthy behaviours in all stages of life when it comes to drinking alcohol, but we believe this must also be in the context of protecting local public spaces/activities that have a proportionately positive benefit to older people's health.	The Public Health Advisory Committee (PHAC) considered the importance of social interaction throughout the guideline development process. The PHAC heard expert testimony on psychosocial factors in relation to delaying disability, dementia and frailty. The PHAC discussed the evidence and felt that it was insufficient to make a recommendation. Please see Expert Paper 7.
Age UK	1.2	1	4	Recommend adding to final sentence on the page: ", recognising that frailty is not widely understood as being preventable".	Thank you for your comment. The Public Health Advisory Committee (PHAC) decided that this recommendation (recommendation 2 in the final guideline) should focus only on dementia prevention in the final guideline.
Age UK	1.4	1	6	This recommendation should also highlight the need to provide inclusive spaces that encourage all-age participation. We believe this	Thank you for your comment. No evidence was found

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				is an important element in establishing longer-term behaviours with regards to health and demonstrating the positive benefit of measures described in the guideline (i.e. through exposure to active older people).	about the benefit for all all-age activities.
Age UK	1.6	1	7	This recommendation should also highlight the need to make sure shopping and healthy food is accessible to all people, e.g. transport enables access to supermarkets or grocery shops and that people are actively encouraged to use local public spaces. For older people and people in mid-life with mobility problems, not accessing these facilities could be because of poor design of public spaces, fear of falling, and/or fear of crime.	Thank you for your comment. The final guideline includes accessibility.
Age UK	1.8	1	8	Addition to following sentence ”But it’s not too late to start making changes if you are already in mid-life *or at any age, including in late old age*”.	Thank you for your comment. This change was not made as the guideline focuses on mid-life. Please see the guideline scope.
Age UK	7.0	7	31	Age UK, the British Geriatrics Society and the RCGP recently published guidance on supporting people living with frailty. For the purposes of the glossary, we recommend using the short definition for frailty used in our guidance (*Fit for frailty, July 2014*): “Living with frailty typically means a person is at a higher risk of a sudden deterioration in their physical and mental health. Frailty is distinct from living with one or more long-term conditions and/or disability, though there may be overlaps in their management. Older people living with frailty can be low users of health services until a relatively minor event precedes a major change in their level of need”.	Thank you for your comment. This definition of frailty has been used in the final guideline.
AIM Alcohol in Moderation	15.0	General		The nineteen Professors and Medics (http://www.aim-	Thank you for your comment.

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				digest.com/digest/pages/council.htm) who are specialists on alcohol and health who sit on AIM's Social Scientific and Medical Council pro bono are concerned that the consistent evidence that drinking within the UK government guidelines of 2-3 units a day for women and 3-4 units a day for men is of particular benefit to older populations is being changed in these recommendations to a suggestion that if all people drink less their outcomes in older age in terms of disability and dementia will be better. A detailed summary of the effects of alcohol on ageing populations by Dr Erik Skovenborg with two hundred relevant references can be read here http://www.drinkingandyou.com/site/pdf/skovaged.pdf More recent papers which ccontinue to re affirm the relationship of small regular doses of alcohol and successful ageing are cited in the draft guidance and later in these comments (such as the Dubbo study and Epic findings). The UK Government guidelines explain that middle aged or elderly non-drinkers or infrequent drinkers and especially those at risk for heart disease "may wish to consider the possibility that light drinking may be of benefit to their overall health and life expectancy." As well as the 'heart-healthy' benefits of moderate drinking to older people, research is also finding that moderate alcohol consumption may reduce the risk of dementia and Alzheimer's disease. Heavy alcohol consumption will, however, cause neural damage and memory loss.	Firstly, this guideline focuses on interventions in mid-life, to prevent or delay disability, dementia and frailty in later life. The evidence considered was drawn from studies focusing on people aged 40-65. The scope for this guideline sets out what is covered in more detail. The report by Skovenborg (date not provided) appears to relate to older people, not those in mid-life, and does not appear to be a systematic review (although no note on the methods is provided). Therefore it is not possible to ascertain the extent to which papers have been systematically vs purposively selected, nor the extent to which any steps have been taken to minimise bias in the report,

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					so we are unable to assess the quality of this evidence based on the information provided. The Dubbo study was published after the evidence reviews were completed. It reports data on older drinkers and is therefore outside the scope of the guideline. It is not clear which of the many publications from the EPIC group is referred to here. The scope of this guideline extends beyond dementia and CVD. It includes other non-communicable diseases that contribute to disability and frailty including alcoholic liver disease, oral cancers and breast cancer where clear links to alcohol

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					consumption and where no protective effect has been demonstrated. The UK alcohol guidelines are currently undergoing review.
AIM Alcohol in Moderation	15.0	General helping them to reduce their alcohol consumption	1	insert to moderate levels or change to keep consumption to within government guidelines	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered a range of evidence on the relationship between alcohol consumption in mid-life and later dementia, disability, and frailty including expert testimony (Please also see the evidence reviews documents 1-7 in the Supporting documents). Based on this evidence, the PHAC were of the view that it would not support the position you suggest here.
AIM Alcohol in Moderation	1.1	Recommendation 1 reduce their alcohol	4	- insert to moderate levels/ or change to keep consumption to within government guidelines	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered a range of

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		consumption			evidence on the relationship between alcohol consumption in mid-life and later dementia, disability, and frailty including expert testimony (Please also see the evidence reviews documents 1-7 in the Supporting documents). The final recommendations represent the consensus of the PHAC based on the available relevant evidence.
AIM Alcohol in Moderation	1.1	Recommendation 1 Make smoking tobacco and drinking alcohol less accessible, affordable and acceptable.	4	Tobacco is only associated with health harms. Drinking alcohol should not be put in the same recommendation. Drinking within government guidelines is associated with increased longevity and better cognitive function for older populations than for those who choose not to drink or to drink to excess. The government guidelines state, based on extensive evidence: that: The UK Government guidelines explain that middle aged or elderly non-drinkers or infrequent drinkers and especially those at risk for heart disease "may wish to consider the possibility that light drinking may be of benefit to their overall health and life expectancy." As well as the 'heart-healthy' benefits of moderate drinking to older people, research is also finding that moderate alcohol consumption may reduce the risk of dementia and Alzheimer's disease. Heavy alcohol consumption will, however, cause neural damage and memory loss.	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered a range of evidence on the relationship between alcohol consumption in mid-life and later dementia, disability, and frailty including expert testimony (Please also see the evidence reviews documents 1-7 in the Supporting documents). The final recommendations

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					represent the consensus of the PHAC on the available relevant evidence.
AIM Alcohol in Moderation	1.5	Recommendation 5 National and local government, Public Health England, trading standards officers and licensing authorities should ensure policies to reduce alcohol consumption are implemented across the population	Page 6	Change to reduce EXCESS alcohol consumption Is it the role of NICE to recommend general population measures which affect the majority of moderate and responsible drinkers rather than targeted interventions and recommendations aimed at the vulnerable, excessive and dependent drinkers?	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered a range of evidence on the relationship between alcohol consumption in mid-life and later dementia, disability, and frailty including expert testimony (Please also see the evidence reviews documents 1-7 in the Supporting documents). The final guideline and recommendations reflect the consensus of the Public Health Advisory Committee (PHAC) on the basis of the available evidence (Please see Supporting documents). Recommendation 7 in the final guideline includes measures to help people who

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					drink to excess levels, as well as supporting the general populations to reduce their consumption.
AIM Alcohol in Moderation	1.8	Recommendation 8 Smoking, lack of physical activity, alcohol consumption, poor diet, and being overweight or obese are risk factors for dementia, disability and fraility	8	Change to excess alcohol consumption . There is no evidence that moderate alcohol consumption (drinking within Government guidelines) is a risk factor for dementia, disability or fraility.	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered a range of evidence on the relationship between alcohol consumption in mid-life and later dementia, disability, and frailty including expert testimony (Please also see the evidence reviews documents 1-7 in the Supporting documents).
AIM Alcohol in Moderation	1.9	Recommendation 9 Informs people that alcohol consumption, even within current guidelines, can increase the	9	This recommendation is challenged. The evidence base shows clearly that moderate drinking is protective in terms of all cause mortality and successful ageing. See page 16 of this guidance on successful ageing. 'Several cohort studies have found links between successful ageing and a person never having smoked (or having quit), exercising regularly, eating fruit and vegetables daily and drinking only a moderate amount	Thank you for your comment. The comparison in the Khaw et al. and Myint et al. papers cited on page 16 of the draft guideline was between moderate drinking with heavy drinking, it does not support the assertion that moderate drinking is healthier than

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		risk of dementia, disability and frailty and encourages them to reduce the amount they drink as much as possible.		of alcohol'. This includes the Dubbo study which finds: Consumption of moderate amounts of alcohol, compared with abstention or with heavy intake, appears to be associated with reduced all-cause mortality (ACM) in middle-aged subjects. The Dubbo Study of Australian elderly is a longitudinal study of healthy ageing. In 1988-89 we examined 2805 non-institutionalised citizens 60+ years of age born before 1930, mean age 69 years. The cohort comprised 1233 men and 1572 women, representing 73% of the eligible population. This report examines the relationship between alcohol intake and mortality in this cohort during follow-up over 20 years. Alcohol intake was arbitrarily grouped into 4 categories: nil, low, moderate and heavy.. 78% of men and 52% of women reported some alcohol intake. Most men reported an intake of 1-14 drinks/week, most women 1-7 drinks/week. Over 20 years to 2008, 66% of men and 53% of women died; 64% of male drinkers died versus 72% of non-drinkers; 46% versus 60% in females. In a multivariate model, ACM was related to quantity of alcohol intake in the familiar "U" shaped relationship, being 20% and 28% reduced in the low and moderate intake categories respectively, compared with nil intake. This relationship was similar in men and women, and with intake of beer or wine/spirits. Any alcohol intake added 12 months survival time in men and women over the follow-up period. Alcohol intake in the low to moderate range appeared to offer protection against the onset of dementia. The overall Dubbo results are not unique, but are applicable to senior citizens. A "healthy survivor" effect may be partially operating in this context. Copyright © 2014 IOS Press. All rights reserved. (Author's Abstract) **Alcohol intake and survival in**	drinking small amounts, or abstinence. The Dubbo study was published after the evidence reviews were completed. It reports data on older drinkers and is therefore outside the scope of the guideline, which focuses on activity and interventions in mid-life.

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				Australian seniors: the Dubbo Study Simons LA Nutrition and Aging Vol 2 No 2-3 pp 85 –90 **See also Kaplan MS, Huguet N, Feeny D, McFarland BH, Caetano R, Bernier J, Giesbrecht N, Oliver L, Ross N. Alcohol Use Patterns and Trajectories of Health-Related Quality of Life in Middle-Aged and Older Adults: A 14-Year Population-Based Study. J. Stud. Alcohol Drugs,2012;73, 581–59l Conclusions:** Persistent moderate drinkers had higher initial levels of health-related quality of life than persistent nonusers, persistent former users, decreasing users, U-shaped users, and inverted U-shaped users. However, rates of decline over time were similar for all groups except those decreasing their consumption, who had a greater decline in their level of health-related quality of life than persistent moderate users **: Kim JW, Lee DY, Lee BC, Jung MH, Kim H, Choi YS, Choi I-G. Alcohol and Cognition in the Elderly: A Review. Psychiatry Investig 2012;9:8-16; On-line:** http://dx.doi.org/10.4306/pi.2012.9.1.8 Ganguli M, Vander Bilt J, Saxton JA, Shen C, Dodge HH. Alcohol consumption and cognitive function in late life: a longitudinal community study. Neurology 2005;65:1210-1217. Stampfer MJ, Kang JH, Chen J, Cherry R, Grodstein F. Effects of moderate alcohol consumption on cognitive function in women. N Engl J Med 2005;352:245-253. Lang I, Wallace RB, Huppert FA, Melzer D. Moderate alcohol consumption in older adults is associated with better cognition and well-being than abstinence. Age Ageing 2007;36:256-261. Ngandu T, Helkala EL, Soininen H, Winblad B, Tuomilehto J, Nissinen	Thank you for bringing these papers to our attention. In relation to the paper by **Kaplan et al.** (2012), as you report the authors conclude that the rate of HRQL decline was the same for all groups, which suggest there is no protective effect of alcohol. They comment that "On the other hand, the present findings offer no support for initiating moderate alcohol consumption in later life to achieve positive health." The authors also point out that people who are decreasing their consumption tend to be people with health problems which would explain their reduced quality of life. In relation to **Kim et al., Ganguli et al., McGuire et al. and Peters et al**. These four papers report data from elderly people and are

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				A, et al. Alcohol drinking and cognitive functions: findings from the Cardiovascular Risk Factors Aging and Dementia (CAIDE) Study. Dement Geriatr Cogn Disord 2007;23:140-149. Launer LJ, Feskens EJ, Kalmijn S, Kromhout D. Smoking, drinking, and thinking. The Zutphen Elderly Study. Am J Epidemiol 1996;143:219-227. McGuire LC, Ajani UA, Ford ES. Cognitive functioning in late life: the impact of moderate alcohol consumption. Ann Epidemiol 2007;17:93-99. **Panza F, Frisardi V, Seripa D, Logroscino G, Santamato A, Imbimbo BP, Scafato E, Pilotto A, Solfrizzi V. Alcohol consumption in mild cognitive impairment and dementia: harmful or neuroprotective? Int J Geriatr Psychiatry 2012;27:1218-1238.** Peters R, Peters J, Warner J, Beckett N, Bulpitt C. Alcohol, dementia and cognitive decline in the elderly: a systematic review. Age Ageing 2008;37:505-512.	therefore outside the scope of the guideline. **Lang et al**. and **Ngandu et al**. These papers are not clear if ex- and never drinkers were separated. Therefore findings may be confounded by the presence of ex-heavy drinkers with health problems in the non-drinking group. **Launer et al**. The publication date for this paper is outside the date range for reviews and other evidence included in this guideline. **Panza et al.** It is noted in the paper that a number of authors express need for caution in interpreting findings of an apparent benefit from alcohol consumption. It is also noted that the findings are not consistent for different types of dementia, nor between some types of dementia and

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					measures of cognitive decline. The final guideline and recommendations represent the consensus of the Public Health Advisory Committee (PHAC) on the available evidence.
AIM Alcohol in Moderation	1.10	Recommendation 10		We are in full agreement with the text used in this recommendation as refers to drinkng	Thank you for your comment. The wording in the final guideline has been changed to 'drinking less alcohol'.
AIM Alcohol in Moderation	4.2	4.2	Page 19	Change to reducing excess alcohol consumption Drinking within government guidelines is not a risk factor for dementia, disability or frailty.	Thank you for your comment. The Public Health Advisory Committee's opinion was that the evidence did not support this change.
AIM Alcohol in Moderation	4.5	4.5	20	Change to reducing excess alcohol intake and binge drinking	Thank you for your comment. The Public Health Advisory Committee's opinion was that the evidence did not support this change.
AIM Alcohol in Moderation	4.13	4.13		Change to unhealthy patterns of drinking	Thank you for your comment. The Public Health Advisory Committee's opinion was that the evidence did not support

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					this change.
AIM Alcohol in Moderation	4.31	4.31 Drinking alcohol daily at home has become normal for some people, and this poses a threat to health.	26	There is no evidence that daily drinking poses a threat to health if it is within government guidelines. Indeed for post menopausal women and men over forty it is this pattern of little and often that is most beneficial for heart health and all cause mortality. It is dose and pattern of drinking which is important, drinking more than 3-4 units a day for men or 2-4 units a day for women leads to an increase in harms, saving up units and drinking heavily on occasions (binge drinking) is also harmful to health, increasing the risk of dementia and cognitive decline for example. Relevant evidence includes for example among 13,894 women in the Nurses' Health Study, investigators prospectively examined alcohol use assessed at midlife in relation to "successful ageing," which was defined as survival to age 70 years, not having a major chronic disease (such as coronary disease, cancer, stroke, diabetes), and having no major cognitive impairment, physical impairment, or mental health problems. Only 11% of the women met these criteria. The results indicate that moderate drinkers were more likely to exhibit successful ageing. For average amount consumed, the largest benefit (an increase of 28%) was among women who reported 15.1 – 30 g of alcohol per day when compared with non-drinkers. The frequency of drinking was especially important: in	Thank you for your response. Please see previous response about the range of non-communicable conditions covered by this guideline.

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				comparison with non-drinkers, women who drank only on 1 to 2 days per week had little increase in their risk of successful ageing, but those drinking on at least 5 days per week had almost a 50% greater chance of successful ageing. Furthermore to quote the draft guideline literature review: The EPIC-Norfolk study found that people who adopted behaviours which include exercise, drinking moderately, not smoking, eating a balanced diet and maintaining a low BMI live an average of 14 years longer than people who did none of them (Khaw et al. 2008). They also had more quality-adjusted life years (Myint et al. 2011).the Whitehall study, people who adopted all 4 behaviours were 3.3 times more likely to age successfully. The association with successful ageing was linear, with people who adopt healthier behaviours having a greater likelihood of successful ageing (Sabia et al. 2012).	The Khaw et al. Myint et al. and Sabia et al. papers were used in the context section of the guideline to give background information on the areas covered, which is not a formal literature review. The evidence reviews supporting the recommendations, which have been systematically developed in line with the scope, can be found at Supporting documents. In the Khaw et al. and Myint et al. papers the majority of people not in the moderate drinkers category were heavy drinkers and the comparison reported was between moderate and heavy drinkers, there was no

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					comparison with non-drinkers and so it is not possible to extrapolate from this that moderate drinking is better than not drinking. In none of the papers was data from ex and never drinkers separated, therefore the non-drinkers outcomes may be adversely influenced by the data from people who have had to stop drinking due to serious health problems.
AIM Alcohol in Moderation	4.32	4.32 The PHAC was aware of the alcohol risk curve seen in the literature that shows a small risk for non-drinkers, a lesser risk for very low drinkers and increasing risk with increasing	27	This sweeping generalisation is extremely concerning and disregards the overwhelming body of evidence on older populations and alcohol consumption from the last 20 years. Studies from the 1980's may have included former drinkers, however ALL recent large meta-analyses exclude former drinkers or 'sick quitters' and any other potential confounders and repeatedly show that moderate drinking, in comparison with abstention, is associated with 20-35% lower risk of cognitive decline and dementia, For example Anstey KJ, Mack HA, Cherbuin N. Alcohol consumption as a risk factor for dementia and cognitive decline: meta-analysis of prospective studies. Am J Geriatr Psychiatry 2009;17:542–555.Lee Y,	Thank you for your comment. The guideline focuses on interventions in mid-life, to prevent or delay disability, dementia and frailty in later life. The scope for this guideline sets out what is covered in more detail. The evidence considered was drawn from studies focusing on people aged 40-65 and therefore these papers would not have

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		consumption of alcohol (however, the risk observed for non-drinkers is likely to be because this group includes former heavy drinkers; these people are likely to be experiencing ill health as a result of past drinking). The expert testimony suggested that there is no safe level of alcohol consumption		Back JH, Kim J, et al. Systematic review of health behavioral risks and cognitive health in older adults. Int Psychogeriatr 2010;l22: 174–187.Neafsey EJ, Collins MA. Moderate alcohol consumption and cognitive risk. Neuropsychiatr Dis Treat 2011;7:465–484.Peters R, Peters J, Warner J, Beckett N, Bulpitt C. Alcohol, dementia and cognitive decline in the elderly: a systematic review. Age Ageing 2008;37:505–512. Unless the expert testimony is unaware of the body of nearly 1000 papers which confirm the existence of the low risk curve showing low levels of drinking to be protective (10g – 20g a day for women and 20-30g for men) – ie those who drink moderately live longer and show more successful levels of ageing than those who don't drink or those who drink heavily, then we would like to see the evidence base that the testimony was based on. An extensive specialist report on alcohol and older people including over 200 references can be read via: http://www.drinkingandyou.com/site/pdf/skovaged.pdf	been included in the reviews. The report by Skovenborg (date not provided) appears to relate to older people, not those in mid-life, and does not appear to be a systematic review (although no note on the methods is provided). Therefore it is not possible to ascertain the extent to which papers have been systematically vs purposively selected, nor the extent to which any steps have been taken to minimise bias in the report, so we are unable to assess the quality of this evidence.
AIM Alcohol in Moderation	4.33	4.33 Alcohol action		As the cited research papers on successful ageing show, one of the protective factors for older people is drinking in moderation in	Thank you for comment. This guideline is about

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		teams and identification and brief advice are not always provided systematically and sufficiently scaled to address health inequalities. The PHAC was also aware that the advice given differs. It is important that all health and social care professionals are given training and information so they can take advantage of intervention opportunities and to make every contact count		comparison with NOT drinking or drinking in excess. Health and social care professionals should be given training and information to ensure their clients understand the responsible drinking guidelines. There is no evidence to show older populations health will improve if they reduce their consumption from moderate levels. To quote the draft guideline literature review: The EPIC-Norfolk study found that people who adopted behaviours which include exercise, drinking moderately, not smoking, maintaining a low BMI behaviours lived an average of 14 years longer than people who did none of them (Khaw et al. 2008). They also had more quality-adjusted life years (Myint et al. 2011).the Whitehall study, people who adopted all 4 behaviours were 3.3 times more likely to age successfully. The association with successful ageing was linear, with people who adopt healthier behaviours having a greater likelihood of successful ageing (Sabia et al. 2012).	interventions in midlife to prevent or delay disability, dementia and frailty in later life (Please see the scope). The final guideline represents the consensus of the Public Health Advisory Committee on the available evidence (Add link to evidence) for this group of people aged 40-65.

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Alzheimer's Research UK	20.0	Introduction		Alzheimer's Research UK is the UK's leading dementia research charity. Since 1992 we have been committed to defeating dementia through research. As research experts, we specialise in funding world-class, pioneering projects at leading universities to find preventions, treatments and a cure for dementia. We believe science and innovation hold the key to defeating dementia. As part of our research portfolio we have funded projects on prevention of dementia.	Thank you for your comment.
Alzheimer's Research UK	15.0	General		We welcome the publication of this guideline, which will help to raise awareness of the potential actions to reduce risks of developing dementia. Public understanding of how lifestyle activities might contribute to developing dementia is currently very low, and therefore public health interventions are urgently needed to improve awareness and understanding. There is also relatively limited knowledge among health and care practitioners of how to reduce risks of developing dementia, and this knowledge base needs to be improved through training and support. We also welcome the broad approach adopted by the guideline, reflecting the need for public health interventions to be wider than simply clinical practice.	Thank you for your comment.
Alzheimer's Research UK	15.0	General		Currently a clear deficiency within the evidence base relates to evaluation and implementation of prevention research. A critical mass of evidence suggests action to mitigate key cardio vascular risk factors can, in some cases, reduce the risk of some dementias. However, to understand if any intervention will work we need evaluations with much longer follow up. NICE should be making this case to policy makers.	Thank you for your comment. The final guideline retains the recommendations to policy makers (Please see recommendations 1-5 and 7-9 in the final guideline).

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Alzheimer's Research UK	1.1	1 Draft Recommendations	4	We support the choice of risk factors listed, as these cover many of the key risk areas. However there are factors, such as depression, diabetes and hypertension, which are not covered by this guidance. It is not clear why they are not included, when there is evidence, as summarised by Barnes and Yaffe, 2011, for them being risk factors for dementia. Given the relatively poor public and professional understanding of dementia risks, it is important that there is every opportunity for all evidence-based factors to be considered. We appreciate that there might be issues around evidence base for direct causal links or that these particular factors are not applicable in terms of primary prevention, however it would be helpful to have the rationale for their exclusion.	Thank you for your comment. To manage this referral within the time and resources available, the draft scope which went out for consultation with stakeholders before development began proposed limiting the outcomes to changes in behaviour and the development of dementia disability and frailty. This focus was included in the final scope. NICE has published guidance previously on the prevention of type 2 diabetes and cardio-vascular disease and it was not considered a good use of resources to re-review the literature on these outcomes. The guideline cross references to these two guidelines.
Alzheimer's Research UK	1.2	1 Draft recommendations:	P4	We support the approach of adding dementia to other non-communicable diseases in terms of public health messaging given that	Thank you for your comment.

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		recommendation 2		they have broadly similar lifestyle behaviours. This provides an opportunity to strengthen the broader message around lifestyle changes and healthy living.	
Alzheimer's Research UK	1.8	1 Draft recommendations: recommendation 8	P8	The recommendations claim that the earlier healthy changes are made, the greater the likelihood of reducing the risk of dementia. It is not clear what evidence supports the claim that earlier intervention will reduce the risk more.	Thank you for your comment. The statement in the guideline refers to disability and frailty as well as dementia. Evidence reviewed for previous guidelines e.g. Preventing type 2 diabetes: risk identification and interventions for individuals at high risk, shows that adopting healthy behaviours increases the years free from non-communicable chromic conditions that contribute to dementia, disability and frailty.
Alzheimer's Research UK	1.11	1 Draft recommendations: recommendation 11	P11	It is unclear how those individuals, who already have existing health conditions that might reduce mobility, and prevent individuals undertaking employment might be engaged with to minimise their lifestyle risks, given that they are unlikely to be able to access leisure centres or workplaces. This is particularly pertinent given that physical inactivity and/or social exclusion are risk factors in themselves.	Thank you for your comment. The Public Health Advisory Committee (PHAC) acknowledge that for some groups of people certain behavioural changes may be more difficult than others. It is

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					therefore important that environmental changes support behaviour change and that services provide tailored support and advice as stipulated in the recommendations.
Alzheimer's Research UK	4.30	4 Considerations: paragraph 4.30	P26	We would support the broadening of the NHS health check to cover information on all types of dementia. It is important to ensure that there is adequate provision within NHS services to support anyone seeking diagnosis as a consequence of the health check.	Thank you for your comment.
Alzheimer's Research UK	5.0	5. Recommendations for research and 11. Gaps in evidence	P27 P43	We support the recognition that further research is needed in this area, particularly in terms of better understanding of the relationships and interactions between risk factors. There is limited mention of the need for more evidence to support interventions for depression, and if appropriate diabetes and hypertension. We also need more evaluations that focus upon long-term follow-up to understand the impact of interventions in preventing dementia.	Thank you for your comment. The need for long-term follow up has been emphasised in the final guideline.
Alzheimer's Society	15.0	General		Alzheimer's Society welcomes this guidance. We see it as part of a positive shift in public health thinking in regards to dementia, and support the principle of encouraging prevention strategies in mid-life. This is consistent with the Blackfriars Consensus, of which we are a	Thank you for your comment. NICE are currently updating the clinical guideline on Dementia which may cover

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				signatory. We would like to see further guidance which emphasises the importance of maintaining healthy lifestyles beyond midlife, and ways that people can be encouraged to live well if they do develop dementia to prevent the condition deteriorating quickly.	secondary prevention .
Alzheimer's Society	15.0	General		We recognise the importance of, and evidence for, addressing mid-life **cardiovascular** risk factors for dementia. We endorse and support the guidance on these. However, we feel that the guidance, in focusing so strongly on cardiovascular risk, does not sufficiently address **psychosocial** risk factors, particularly depression, flagging these only as areas needing further research. We note that several recent analyses of mid-life risk concluded that there is now sufficient evidence to include psychosocial factors such as depression alongside cardiovascular factors, for example Norton et al (2014) Lancet Neurology, and International Longevity Centre (2014) ILC London . Suggestions on this issue are made in specific comments according to section number.	Thank you for your comment. In addition to searching for evidence in this area for the evidence reviews, the Public Health Advisory Committee (PHAC) received expert testimony on psychosocial risk factors. Please see Expert paper 7. The final recommendations reflect what the PHAC felt they were able to recommend, based on this evidence – this was an area where little evidence was identified. Thank you for bringing these papers to our attention. They were both papers were published during the consultation period for the guideline and so after the evidence reviews were

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					completed. NICE guidelines are routinely reviewed for update at two years post publication, and this evidence will be considered at that point.
Alzheimer's Society	15.0	General		We also feel that the guidance is inconsistent in its message on alcohol. We address this in specific comments according to section number.	Thank you for your comment. The wording around alcohol consumption has been revised in the final guideline.
Alzheimer's Society	0.0	'What is this guideline about?'	1	We would suggest that the initial suggestion for promoting change in various behaviours should mention avoiding depression and remaining socially connected.	Thank you for your comment. The final guideline mentions social interaction.
Alzheimer's Society	1.0	National and Population-level initiatives	4	We would suggest an additional recommendation in this section encouraging social connectedness and interventions to avoid depression.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider there was sufficient evidence to make this change.
Alzheimer's Society	1.8	Recommendation 8	8	We would recommend that under the bullet to 'Aim campaigns at the general population…' where it is stated that "Smoking, lack of physical activity, alcohol consumption, poor diet and being overweight or obese are risk factors for dementia, disability and frailty' that social isolation and depression are also mentioned as risk factors, as substantiated by the evidence.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider there was sufficient evidence to make this change.
Alzheimer's Society	1.9	Recommendation 9	9	The statement that 'alcohol consumption even within current guidelines can increase the risk of dementia' is inconsistent with the point in	Thank you for your comment. The wording around alcohol

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				recommendation 10 that prevention programmes should help participants change behaviour where they drink more alcohol than is recommended by the Chief Medical Officer.	consumption has been revised in the final guideline.
Alzheimer's Society	1.10	Recommendation 10	10	We would suggest that the point to 'Help people to identify and find ways to overcome social and psychosocial factors that may prevent them from making positive changes to improve their health' should also include reference to the evidenced psychosocial factors which can help delay or prevent dementia.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider there was sufficient evidence to make this change.
Alzheimer's Society	4.22	4.22	24	We feel that the guidance acknowledges that importance of psychosocial risk factors, but this acknowledgement is then sidestepped with the recommendation for more research. The nature of psychosocial factors means that medical research is less likely to be available as these factors are harder to measure. While more research would be welcome, we also feel that there is a place within the recommendations for raising awareness of these factors whilst evidence on specific interventions is developed. We feel that if this is not included in the recommendations it could be damaging to the way that these factors are considered in future, placing psychosocial risk factors on a lower footing than cardiovascular risk factors.	Thank you for your comment. Please see previous response.
British Geriatrics Society	15.0	General		The inclusion of a specialist from geriatric medicine and a specialist from the dementia field are significant omissions from the guidance preparation group.	Thank you for your comment. Recruitment to the Public Health Advisory Committee (PHAC) followed standard NICE procedure. Topic specialists were recruited from the applicants

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					who responded to the advert for members.
British Geriatrics Society	15.0	General		Focus should be changed so that dementia is highlighted- it's probably more of a driver for most people to change behaviour as it's one of the most feared diseases, whereas disability and frailty are more nebulous	Thank you for your comment. The guideline reflects the Department of Health's referral, and the final scope which was the subject of stakeholder consultation.
British Geriatrics Society	15.0	General		The value or harm associated with e-cigarettes has not been mentioned.	Thank you for your comment. The guideline cross references to the tobacco harm reduction guideline which includes alternative sources of nicotine.
British Geriatrics Society	15.0	General		The importance of sleep disorders is overstated especially in research recommendations, when compared to the importance of maintaining regular social activity which is minimally apparent in the draft. The balance of the importance of these two issues needs to be addressed.	Thank you for your comment. The Public Health Advisory Committee (PHAC) are required to prioritise areas for future research for inclusion in section 5. The included areas reflect their opinion of the importance and likely benefit based on the available evidence.
British Geriatrics Society	15.0	General		Weight reduction/ avoidance of obesity guidance seems to be excluded probably because there is another guideline on this, but it is	Thank you for your comment. The Obesity guidance CG43

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				important refs to the other guideline could be increased	is undergoing an update. Part of it has already been updated and replaced by PH53 Overweight and obese adults - lifestyle weight management We are satisfied that the guideline cross references to other NICE guidelines on weight management where appropriate.
British Geriatrics Society	1.14	Recommendation 14		Health and Wellbeing Board should work with County, City and Town Council Planning Boards to encourage development of adult recreational facilities within parks alongside children's recreational facilities, to enable parents and grandparents to exercise when taking children to the park or when out on their own.	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered the wording in the draft guideline to be sufficient to cover these types of activities.
British Geriatrics Society	1.4	Recommendation 4		As above but directed at architects and planners	Thank you for your comment. Please see previous response.
BUPA	1.3	1 Draft recommendations. Recommendation 3	5	Inclusion of workplaces of employers in all sectors as key hub for change- enabling and encouraging healthy behaviours such as smoking cessation.	Thank you for your comment. There is a recommendation specifically for employers later in the guideline.
BUPA	1.6	1 Draft recommendations.	6	Limiting the number of fast food outlets near schools and workplaces is referenced. We would encourage this to be broadened to include the	Thank you for your comment. Later in the guideline there

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		Recommendation 6.		reduction in availability of fast food on school and workplace menus, as well as their availability within a nearby vicinity.	are recommendations for employers and for public sector employers to lead by example that cover this point.
BUPA	1.7	1 Draft recommendations. Recommendation 7.	7	Very supportive of this – private sector organisations supporting healthy living.	Thank you for your comment.
BUPA	1.8	1 Draft recommendations. Recommendation 8.	8	It could be considered to be more specific on the age ranges that have a greater likelihood of reducing the risk of dementia. And tailoring the message to different age groups to be more effective. For example a campaign targeted at people in their 40's would be different to those in the 20's.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not agree that this needed to be more specific.
BUPA	1.8	1 Draft recommendations. Recommendation 8.	8	The suggested campaign messages assume a base level of knowledge about dementia. We suggest a short key message on what dementia is and the status of available disease-modifying drug treatments.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not agree that this change was necessary.
BUPA	1.13	1 Draft recommendations. Recommendation 13.	12	We suggest including some more examples in earlier life stages, most are directed at the over 40's. E.G could also include taking advantage of the times in life when substantial change occurs: during pregnancy, when starting a new school, starting university. We also suggest drawing out what is distinctive about dementia i.e. what are the differences that would need to be included in campaigns for dementia. The importance of social activity and challenging the	Thank you for your comment. The examples reflect the age focus of the referral from the Department of Health. Thank you for your comment. The Public Health Advisory Committee (PHAC) did not

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				brain are distinctive for dementia.	agree that this change was necessary. There was a lack of evidence about social activity and cognitive activities.
BUPA	15.0	General		Be more specific about the age range 'mid-life' covers, and which risk factors are distinctive for dementia, and how existing NCD campaigns would need to be evolved.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not agree that this change was necessary. The guideline clearly states mid-life as being 40- 65.
BUPA	1.1	1 Draft Recommendations. Recommendation 1.	4	No mention of promoting mental wellbeing here., but is it mentioned several times throughout the paper, including in recommendation 12. Mental wellbeing could be considered to be included in recommendation 1.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not agree that this change was necessary.
Care & Repair England	15.0	**General**		Whilst the guidance is focused on behavioural risk factors and changing behaviours, many of the chronic health conditions experienced by older people have a link to or are exasperated by their environment particularly poor and inappropriate housing. The draft guidance acknowledges the importance of basic needs being met such as housing and employment in Section 4.9. Here the report states that people are more likely to make healthy choices /change behaviours when basic needs – including housing – are addressed.	Thank you for your comment. Thank you for your comment. The consideration was based on the experience of the PHAC. No evidence from

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				We believe this to be the case and would therefore urge that the report recognises much more overtly the link between poor housing and poor health and the role that housing interventions can make in supporting people to lead healthier lives. In support of this we would draw your attention to Building Research Establishment data that poor housing is estimated to cost the NHS at least £600 million per year {BRE and CIEH Good housing leads to good health (2010.)} There is a causal link between housing and the main long term conditions (heart disease, stroke, respiratory, arthritis) whilst risk of falls, a major cause of injury and disability, hospital admission and demand for care and support amongst older people, is significantly affected by housing characteristics and the wider built environment. There is also a wide and expanding evidence base concerning the value of housing interventions for good health and wellbeing. This includes evidence of enablement, the impact of supported housing, home adaptations and other environmental interventions such as falls prevention all of which is strong and well documented. Three reports that have summarised this evidence base are • Pathways to prevention. Hact. (2011) • Housing, prevention and early intervention work: a summary of the evidence base. Housing LIN (2011) • On the Pulse from the National Federation of Housing Associations (2011)	mid-life populations was found that evaluated its impact on the prevention of dementia, disability and frailty, therefore the PHAC did not consider it appropriate to make a recommendation in this guideline. NICE published a guideline on Preventing excess winter deaths, the scope of which covers some of the issues you raise http://www.nice.org.uk/guidance/ng6

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				As a result it would be sensible, in midlife, to encourage people to review their housing circumstances and environment and help them to do so. Access to good quality independent specialist advice, information and support on housing matters for people throughout life is key combined with actions to improve people's housing circumstances. Both should be seen to be within the scope of this NICE guidance given that its focus is on prevention in midlife to increase the number of older people who can lead independent, healthy and active lives. Practical measures such as warm, safe, well designed housing, the effective delivery of home adaptations and repairs services, aids, equipment and assistive technologies can all have quantifiable effects with regard to health, well-being and independent living. Planning for later life should include a review of home circumstances considering measures that might mitigate the effects of cold, damp and disrepair and hazards in the home that could impact on poor health and disability. To illustrate here are some examples of the impact of housing related interventions • One in three people over 65 and one in two of those over 80 years will suffer a fall each year {DH Falls and fractures: effective interventions in health and social care.} Multifactorial intervention which addresses muscle tone (exercise), reviews	

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				medication and modifies the home (adaptations and hazard removal) is the most effective way to reduce falls risk. Falls and accidents can be significantly reduced by simple adaptations such as handrails. Rapid low cost adaptations to homes, as delivered by handypersons services, make savings of £1.70 for every £1 (savings to health, social care and police) - Housing prevention and early intervention at work: a summary of the evidence base Housing LIN (2011) • In 2010, at least 4 million households had someone with mobility problems. Four key features can maximise people's independence and mobility (level access and flush thresholds; sufficient door width; circulation space; toilet on ground / entry floor) but only 1 million homes have these (5%) and 6 million (26%) have none. English Housing Survey DGLG (2010) • Cold homes have serious impact on health. The Marmot Review team report {The Marmot Review Team. The health impacts of Cold Homes and Fuel Poverty. Friends of the Earth (2011)} concluded that there is strong relationship between cold temperatures and cardio vascular and respiratory diseases. The current draft guidance only looks at the environment in relation to better promotion of physical activity. Care & Repair England believes that it should also look at the home environment and its role in prevention encouraging better planning for later life by discussing and promoting in the guidance information, advice and measures to make	

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				people's homes decent, safe and warm for later life.	
Care & Repair England	1.4	Section 1	Page 4	*Recommendation 4* - This section should be expanded to include risk factors in the home environment and measures to prevent them as well as information on where to go to find out about housing options in later life (see next two sections)	Thank you for your comment. We looked for evidence on wider social factors. No evidence from mid-life populations was found that evaluated the impact of risk factors in the home environment on the prevention of dementia, disability and frailty, therefore the PHAC did not consider it appropriate to make a recommendation in this guideline. NICE ipublished a guideline on Preventing excess winter deaths, the scope of which covers some of the issues you raise http://www.nice.org.uk/guidance/ng6
Care & Repair England	1.8	Section 1	Page 7	*Recommendation 8* - The awareness and information campaign developed in recommendation 8 and 9 should be expanded to consider people's home environment and include awareness and advice on reducing hazards, keeping homes in good condition, tackling	Thank you for your comment. We looked for evidence on wider social factors. No evidence from

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				repairs, looking at safety and security issues in the home and improving heating and insulation all aimed at making homes decent, warm, safe and secure for later life. It should also enable people to consider housing options and be aware of what is available - there are sources of advice on housing in later life – see First Stop. http://www.firststopcareadvice.org.uk/	mid-life populations was found that evaluated the impact of risk factors in the home environment on the prevention of dementia, disability and frailty, therefore the PHAC did not consider it appropriate to make a recommendation in this guideline. NICE published a guideline in March 2015 on Preventing excess winter deaths, the scope of which covers some of the issues you raise http://www.nice.org.uk/guidance/ng6
Care & Repair England	1.9	Section 1	Page 8	*Recommendation 9* - The awareness and information campaign developed in recommendation 8 and 9 should be expanded to consider people's home environment and include awareness and advice on reducing hazards, keeping homes in good condition, tackling repairs, looking at safety and security issues in the home and improving heating and insulation all aimed at making homes decent, warm, safe and secure for later life. It should also enable people to consider housing options and be aware of what is available - there are sources of advice on housing in later life – see First Stop. http://www.firststopcareadvice.org.uk/	Thank you for your comment. Please see previous response.

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Care & Repair England	4.9	Section 4.9	Page 21	*Considerations* - This section should be expanded to look at housing in the context of risk factors setting out what people might consider, how and where people can obtain advice and information and practical support on considering their home circumstances to support them to live healthy lives. (See our General response on this aspect).	Thank you for your comment. This section summarises the issues discussed by the PHAC when making recommendations.
Care & Repair England	4.14	Section 4.14 onwards	Page 22	*The evidence* - This section needs to consider the evidence for specific housing interventions as highlighted in our general comment on the draft guidance.	Thank you for your comment. We looked for evidence on wider social factors. No evidence from mid-life populations was found that evaluated the impact of risk factors in the home environment on the prevention of dementia, disability and frailty, therefore the PHAC did not consider it appropriate to make a recommendation in this guideline. NICE published a guideline in March 2015 on Preventing excess winter deaths, the scope of which covers some of the issues you raise http://www.nice.org.uk/guidance/ng6

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Chartered Society of Physiotherapy	15.0	General		The CSP welcomes this guidance, the aim of which is well aligned with the aims of the physiotherapy profession as a whole i.e. to increase the number of older people who can lead independent, healthy and active lives. We will support the implementation of the relevant sections of this guidance to our membership by publicising the release of these guidelines when they are finalised, signposting members to relevant recommendations.	Thank you for your comment.
Chartered Society of Physiotherapy	1.10	Recommendation 10	10	Consider signposting to NICE guidelines on behaviour change: individual approaches (PH49) in this section.	Thank you for your comment. This recommendation in the final guideline cross references to PH49.
College of Occupational Therapists	1.1	Recommendation 1	4	We support this recommendation, however, we believe consideration should be given to mental health barriers e.g. anxiety, depression, worried well, mal adaptive responses to stress- all prevalent in society. Underlying causes must be addressed as these can lead to unhealthy behaviours as a coping mechanism e.g. excessive food intake; smoking and high alcohol consumption.	Thank you for your comment. Recommendation 9 in the final guideline includes a focus on helping people to address personal barriers to behaviour change.
College of Occupational Therapists	1.4	Recommendation 4	5	Final para: ..on a [permanent] REGULAR ONGOING basis.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider this addition

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					necessary.
College of Occupational Therapists	1.4	Recommendation 4		Encourage local government's plans to include accessible and safe public transport to aid access to community venues.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider reference to public transport to be appropriate to this recommendation as no evidence was found about the role of public transport.
College of Occupational Therapists	1.4	Recommendation 4	5 & 53	A further sub point following road infrastructure should include: incorporate adequate change and shower facilities in the work place. Many people who would wish to participate in healthy activity en route to work/ during lunch breaks do not due to lack of facilities. (Not covered in physical environment).	Thank you for your comment. This is pertinent to the recommendation for employees and is in the guideline it cross references to.
College of Occupational Therapists	1.6	Recommendation 6	6	We agree with measures to control the sale of unhealthy foods and fast food outlets. This recommendation should include reducing the availability of unhealthy foods within health and social care premises. For example, hospital vending machines and fast food outlets on hospital sites. See http://www.wcrf-uk.org/about_us/policy_advocacy/vending_machines.php	Thank you for your comment.
College of Occupational Therapists	1.8	Recommendation 8	7-8	We agree that the use of social media to raise awareness would be beneficial, including the use of Apps.	Thank you for your comment.
College of Occupational	1.8	Recommendation	8	Para 4 also make messages upbeat and informative rather than guilt-	Thank you for your comment.

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Therapists		8		inducing. The recent BBC documentary by Michael Mosley on meat consumption is an excellent example; people are already making important dietary changes as a result.	
College of Occupational Therapists	1.8	Recommendation 8	8/53	Public Health strategies and NHS strategies to enable access to activity, housebound or micro environment living older people will find it challenging to participate in activity unless they are assisted.	Thank you for your comment the Public Health Advisory Committee (PHAC) are aware that providing opportunities for physical activity will be more challenging for some groups of people.
College of Occupational Therapists	1.8	Recommendation 8	8-9 &/53	Bullet point 3, Older people are a high risk group, often not technologically savvy and often require low tech support. Equally older people with visual impairments are a marginalised group when it comes to activity and require person centred training and at best incorporation into everyday tasks (evidence can be located: Waterman, Ballinger & Skelton, Visual Impairment and Falls OT input in home safety and exercise interventions VIP2 UK Trial) 2011.	Thank you for bringing this work to our attention. It is on older people who are outside the scope for this guideline.
College of Occupational Therapists	1.10	Recommendation 10	10	There should be links to resources about physical activity. Within health checks for those with a learning disability, falls history should be added to the yearly health check/ MOT.	Thank you for your comment. The provision of advice and support to make behavioural changes is already an integral part of the NHS Health Checks programme. lifestyle change. The Expert Scientific and

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					Advisory Panel for NHS Health Check has a developed a content review process that would have to be followed to make changes to the content. Amending or introducing new content requires the approval of the government.
College of Occupational Therapists	1.10	Recommendation 10	10	A point should be included around encouraging those who already have a diagnosis of diabetes/cardiovascular disease to access treatments and to comply with medication prescribed.	Thank you for your comment. Management of existing conditions is outside the scope of the guideline.
College of Occupational Therapists	1.12	Recommendation 12	11 & 53	Bullet point 3, following the dashed sub bullets consider including: Regular medication interaction consequences with alcohol and essential vitamin supplements.	Thank you for your comment. This was not part of the intervention evaluated in the research.
College of Occupational Therapists	3.0	3 Context	Discussed on page 16	Should people be encouraged to access services to receive treatment for hearing and visual impairment e.g. treatments for eye conditions, glasses, hearing aids? Many people have hearing and visual impairments but do not make use of the aids available to help with this.	Thank you for your comment. The Public Health Advisory Committee (PHAC) received expert testimony about the impact and management of hearing loss (please see Expert paper 10). Their view was that the evidence is currently insufficient to support a recommendation

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					but they have made a research recommendation about hearing and visual loss.
College of Occupational Therapists	9.0	9 Other reviews: Review 1	37	Issues that prevent or limit OR PROMOTE the uptake and maintenance... [*otherwise you hadn't included facilitators]*.	Thank you for your comment. The title of the evidence review was decided by the review centre. Please see the research question on page 7 of the report for the extent of the evidence covered.
College of Occupational Therapists		General		Media is one of the ways of getting public health messages across, however, most people think it won't happen to them and are in denial of the risks. Clear messages that join-up thinking like '*good for the heart good for the brain'* need to be constantly reinforced. Did the review consider evidence to support incorporating CBT approaches to public health messages e.g. motivational quotes to change internal scripts?	Thank you for your comment. No evidence was found to support Cognitive Behavioural Therapy used in this way.
College of Occupational Therapists	15.0	General		There is no mention of the word 'pain' anywhere. As pain can reduce the ability to exercise so pain can lead to greater levels of 'unfitness'. Support around enabling keeping fit needs to be thought about as not everyone in middle age can cycle etc. Even walking can be painful for some so one disability can lead to further disability following this thinking. Hence the importance of easily accessible occupational therapists/ physiotherapists to enable participation in exercise.	Thank you for your comment the Public Health Advisory Committee (PHAC) are aware that providing opportunities for physical activity will be more challenging for some groups of people. However

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					management of existing conditions is outside the scope of this guideline.
College of Occupational Therapists	5.0	General/recommendations for research		One contributor commented '*within our osteoporosis service we are seeing an increasingly younger population of patients being diagnosed. Some of these purely due to lack of weight bearing exercise and lack of any exposure to the sun. Should there be a healthy sun exposure message? I would certainly suggest this document should recommend that research be undertaken regarding Vitamin D levels and the impact on dementia, falls, frailty, and other health issues'.*	Thank you for your comment. NICE is currently developing a guideline on Sunlight exposure which is due to publish later this year http://www.nice.org.uk/guidance/indevelopment/GID-PHG77
ENT UK (British Association of Otolaryngologists)	1.1	Recommendation 1	4	Regarding smoking and alcohol reduction: The UK Cognitive Function and Ageing Study (CFAS) found that 'alcohol and smoking (never, past and current) were neither strongly protective nor predictive' of developing dementia in later life (see http://www.cfas.ac.uk/pages/hrisk/index.html). The evidence base for this recommendation may need reconsideration.	Thank you for your comment. The referral from the Department of Health was not just about dementia but also about preventing disability and frailty. The Public Health Advisory Committee (PHAC) had to balance these outcomes. Alcohol is a risk factor for some cancers. Smoking is a risk factor for many NCCDs. The evidence about associations with dementia is presented in expert paper 1

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					and the accompanying publication 'Promoting Brain Health' from the UK Health Forum.
ENT UK (British Association of Otolaryngologists)	1.0	Draft Recommendations: General	4 - 53	We have reviewed the 16 recommendations and are concerned that the crucial role played by hearing in cognitive well-being has been overlooked. Being able to communicate and socialise is central to healthy ageing and this is heavily dependent on optimising sensory inputs to the brain - both auditory and visual. We will not comment on the importance of vision inputs (assuming that others will do so) but the evidence clearly shows that mild, moderate and severe hearing loss is independently associated with a 2 - , 3- , 5 – times risk of developing dementia (1). These authors estimated the attributable risk of dementia associated with hearing impairment to be 36%. We feel that this alone is sufficient evidence to warrant a recommendation that maintenance of hearing health be considered a key priority in delaying the cognitive decline associated with ageing. This contrasts with the weak evidence supporting your main recommendation regarding smoking cessation and alcohol consumption where the results of a large UK Cognitive Function and Ageing Study (CFAS) found that 'alcohol and smoking (never, past and current) were neither strongly protective nor predictive' of developing dementia in later life (2). A degraded hearing input (as happens in age-related hearing loss) results in greater cognitive resources being required for auditory perceptual processing to the detriment of other real-time cognitive processing needs (such as attention, working memory etc). Recent	Thank you for your comment. The scope for this guideline does acknowledge the importance of hearing in cognitive wellbeing. This guideline focuses on interventions in mid-life (before the onset of age-related conditions), to delay or prevent dementia, disability and frailty. We did search for published evidence on this in relation to hearing and hearing loss when developing the evidence review, but found very little. We then sought expert testimony on mid-life interventions to prevent later hearing loss, and this was considered by the Public Health Advisory Committee (see Expert paper 10.) The

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				studies (from human and animal models) have clearly shown that an impoverished auditory input precipitates changes in the organisation of the cortex and brain morphometry (3, 4). A further study in 2014 (5) demonstrated that individuals with hearing impairment have accelerated rates of whole brain atrophy and specific volume declines in the superior, middle and inferior temporal gyri – areas that are not only important to spoken language processing but also essential for semantic memory and sensory integration; these same areas have been shown to be also involved in the early stages of Alzheimer's disease (6). Auditory prostheses play an important part in reducing the impact of a hearing loss but uptake rates are abysmally low (less than one in 7 of the UK population who could benefit from a hearing aid actually wears one) and they are typically provided after 10 - 15 years of auditory deprivation. Many individuals live in denial of their hearing loss and only accept to seek help after pressure from frustrated relatives or carers. Hearing aids are seen as stigmatising, making people 'feel old', drawing attention to a deficit they avidly seek to hide. And provision of hearing aids alone is not sufficient – counselling, training, environmental and life-style adjustments are also needed, preferably soon after the onset of hearing loss and prior to the onset of cognitive decline. Novel approaches, such as smartphone technologies, could change this perception and make hearing assistive devices more acceptable to a wider group of individuals, especially the 'young old'. 1. Lin F. et al Hearing loss and incident dementia Arch. Neurol. 2011,68, 214 – 220	final guideline represents what the PHAC felt they were able recommend on the basis of the available evidence. A research recommendation is made in this are (Please see section 5.4 in the final guideline).

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				2. Cognitive Function and Ageing Study (CFAS) http://www.cfas.ac.uk/pages/hrisk/index.html 3. Peelle JE et al. Hearing loss in older adults affects neural systems supporting speech comprehension. J Neuroscience 2011, 31(35),12638 – 12643 4. Groschel M et al Differential impact of temporary and permanent noise-induced hearing loss on neuronal cell density in the mouse central auditory pathway. J Neurotrauma 27(8) 1499 – 1507 5. Lin F. et al Association of hearing impairment with brain volume changes in older adults. Neuroimage 2014, 90 ,84 – 92. 6. Chetelat G et al Using voxel based morphometry to map the structural changes associated with rapid conversion in MCI Neuroimage, 2005, 27 (4), 934 - 946	
ENT UK (British Association of Otolaryngologists)	4.20	General Considerations. The Evidence 4.20	23	This is no longer the case. A significant body of high-quality, recent research confirms the unequivocal relationship between hearing loss and cognitive decline. A comprehensive review of this literature as well as commentary from leading experts in dementia research can be found in the proceedings of a recent workshop at the U.S. Institute of Medicine and entitled 'Hearing Loss and Healthy Ageing'. Source: Institute of Medicine. (2014). IOM/NRC Workshop on Hearing Loss and Healthy Aging. Retrieved from http://www.iom.edu/hearingloss-aging	Thank you for your comment. The final recommendations represent what the PHAC agreed they were able to recommend, based on the available evidence, which included expert testimony on this topic (Please see Expert paper 10). The paper you cite was published after the evidence reviews were completed. It may inform a future update of the

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					guideline, if it fits within the scope for mid-life intervention.
ENT UK (British Association of Otolaryngologists)	11.0	Paragraph 5	44	The draft guidance correctly points to a lack of evidence of effectiveness and cost-effectiveness of auditory prostheses in arresting cognitive decline in older individuals. The critical question: does appropriate management of a hearing loss reduce, delay or modify the risk of later cognitive decline? – remains unanswered. This requires carefully designed, randomised, prospective controlled clinical trials to address this important gap in knowledge and to better understand the underpinning pathways linking hearing loss and cognitive decline. The UK is particularly well positioned to address such questions as the hearing research community and its voluntary sector has a long track record of undertaking seminally important population studies on hearing loss and its cognitive sequelae. This gap in knowledge is recognised in a recent Editorial in *Aging and Mental Health* (1) and such studies are about to begin in the US supported by the National Institutes of Health. 1.Lin F, Albert M, Hearing Loss and Dementia – who is listening? Aging and Mental Health. 2014; 18 (6) 671 -3.	Thank you for your comment. The Public Health Advisory Committee (PHAC) have made a research recommendation in this area (Please see section 5.4 in the final guideline).
ENT UK (British Association of Otolaryngologists)	5.0	Section 5; Recommendation	27	Following on the above, we would like to see the definitive guidelines explicitly support the case for research in the UK to evaluate the role of	Please see previous response.

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		s for Research		hearing loss and its rehabilitation in the cognitive decline of our older people. Only through mutli-disciplinary research, linking hearing science with cognitive neuroscience, geronotology and primary care can the place of sensory restoration in cognitive ageing be properly elaborated.	
Food and Drink Federation	1.6	Draft Recommendation 6	6	This submission is made by the Food and Drink Federation, the trade association for food and drink manufacturing. Food and drink is the largest manufacturing sector in the UK (accounting for 15% of the total manufacturing sector) turning over £78.7bn per annum; creating GVA of £20bn and employing up to 400,000 people. Thank you for the opportunity to comment on the National Institute for Health and Care Excellence consultation on approaches to prevent dementia, disability and frailty. We would like to offer comment on recommendation 6 of the draft guidelines, which recommends that government set up a national framework to help people adopt a healthy diet, comprising the following components: 1) Financial and regulatory measures to reduce the level of salt, saturated fat, artificial trans fats and added sugars in processed foods. 2) Limit marketing of foods high in salt, saturated fat, artificial trans fats and added sugars 3) Reduce the availability of foods that can contribute to an unhealthy diet.	Thank you for your comments. 1-3. The wording in the final recommendation is 'reducing the availability and promotion of foods that can contribute to an unhealthy diet. . For example, by reducing or limiting the number of food outlets in a given area selling foods high in salt, saturated fat, artificial trans fats and free sugars. '. 4. The final guideline includes a recommendation that people are helped to understand what constitutes a healthy diet, have access

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				4) Activities to make people aware of what constitutes as healthier food choice. **<u>1) Financial and regulatory measures to reduce the level of salt, saturated fat, artificial trans fats and added sugars in processed foods</u>** We believe voluntary action by industry is the fastest and most effective way of delivering change, and this can be demonstrated by the effective industry action to date, as well as the scale of forward commitments our members have made under the Government's Public Health Responsibility Deal. We do not believe financial or regulatory methods would deliver the scale and speed of change which has already taken place, and which companies have committed to undertake in the future. ***1.1) Voluntary Reformulation*** The UK food and drink manufacturing industry is now widely recognised as leading the world when it comes to voluntarily reformulating products; extending consumer choice; and providing clear on-pack nutrition labelling. FDF members are committed to continuing to respond positively to public health challenges, and to playing their role in helping consumers achieve balanced diets. Examples of the impact of voluntary reformulation include: • **Salt** - As a result of voluntary industry activity, there has been	to affordable fruit and vegetables and have information on how to prepare them.

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				a 10% reduction in salt levels in FDF members' products compared with 2008[15]. • **Trans Fatty Acids** – Voluntary reformulation efforts have virtually eliminated artificial trans fatty acids (TFAs) from the UK diet. The latest data shows that intakes of TFAs are in the UK are 0.7% of food energy for adults[16]. This means that current intakes are less than half of the UK government's recommended maximum TFA intake of 2% of food energy and close to what would be expected from ruminant sources. • **Calorie reduction** – Many companies have signed up to the Responsibility Deal calorie reduction pledge, which includes a wide range of activities from reformulation to developing 'low-in' products and providing a range of portion sizes to enable individuals to select a size appropriate for them. As part of this pledge, many companies have already made, or committed to, a reduction in sugars where this results in a reduction in calories. More information on our members' work under the calorie reduction pledge can be found here. We consider these examples demonstrate the effectiveness of voluntary work. We believe it is necessary for government, advised by bodies such as NICE, to lead the agenda and focus action. However, voluntary work allows individual companies a level of flexibility to	

[15] Kantar data compiled for FDF, January 2013.

[16] National Diet and Nutrition Survey Years 1-4

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				achieve change through resource intensive and challenging innovation. This is necessary as fat, sugars and salt are all present in foods for multiple reasons including flavour, texture, functional raising agents, mouth feel, colour and as preservatives for food safety. The exact role and functions of different ingredients vary depending on the product and it would be impractical for legislation to take this into consideration. Voluntary approaches on the other hand, allow companies to approach a reformulation with the level of flexibility required to implement changes gradually and where most suitable. ***1.2) Food Taxation*** Many foods are already subject to VAT at the standard rate of 20%. We believe that the introduction of further taxes on food and drink would be an ineffective measure in tackling obesity. We do not believe there is any evidence to indicate their value as a public health measure, and furthermore consider they may have unintended consequences of widening social inequalities as well as being difficult practically to implement. Seeking differentially to tax certain foods would impose a larger burden on lower income families[17] who spend a higher proportion of their	

[17] Caraher M, Cowburn G. (2005). Taxing food: implications for public health nutrition. *Public Health Nut* 8:1242–9.

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				income on food and drink and potentially widen health inequalities even further[18]. For instance, Nnoaham *et al*.[19] found that taxes on "unhealthy" food had a regressive effect that was not counterbalanced by greater health gains. In addition, Leicester & Windmeijer[20] estimated that higher income households would spend less than 0.1% of their income on a fat tax in the United Kingdom, compared with 0.7% for low income households. We also believe taxing foods based on the levels of a particular nutrient(s) would pose considerable difficulty in terms of practical implementation. In particular, a method of categorising foods as healthy/less healthy, or high/low in sugar, fat, salt, would be required to implement such a policy. No such nutrient profiling tool currently exists for this specific purpose. The implementation of such a tax would impose a burden on producers, importers and retailers, as there would be a heavy degree of bureaucracy involved in establishing the amount of tax on domestically produced or imported goods. **2) Limit marketing of foods high in salt, saturated fat, artificial**	

[18] Tiffin R & Salois M (2012) Inequalities in diet and nutrition. Proceedings of the Nutrition Society, 7, 105- 111

[19] Nnoaham KE, Sacks G, Rayner M, Mytton O, Gray A. (2009). Modelling income group differences in the health and economic impacts of targeted food taxes and subsidies. *Int J Epidemiol* 38:1324–33.

[20] Leicester A, Windmeijer F.(2004) *The "fat tax": economic incentives to reduce obesity.* London: Institute for Fiscal Studies

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				trans fats and added sugars We believe that individuals can make appropriate choices for themselves and their families, but that our members can help consumers by continuing to offer a range of products and portion sizes, to meet a range of needs. With respect to the advertising of products, the UK advertising industry is governed by strict codes of practice that are designed to protect consumers and create a level playing field for advertisers. The codes are self-regulatory and cover all kinds of promotional communications. The UK Code of Broadcast Advertising (BCAP Code) applies to the content and scheduling of television and radio advertisements. The UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing (CAP Code) applies to advertisements across media including newspapers, magazines, billboards, posters, leaflets, mailings, e-mails, texts and on UK based company websites. The codes are underpinned by consumer protection legislation and fully reflect UK and EU law. They are also frequently reviewed to take account of new technology and changing public and policy concerns. Both codes include general rules that state advertising must be responsible, must not mislead, or offend.	

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				Although there are additional restrictions of the TV advertising of HFSS[21] foods to children, the advertising regulator has not deemed restrictions on the advertising of HFSS foods to adults as a necessary measure. The Advertising Standards Authority (ASA) is the UK independent regulator for advertising across all media. ASA responds to complaints and proactively checks the media to take action against misleading, harmful or offensive advertisements, sales promotions and direct marketing. If ASA judges an advert to be in breach of the Codes, it must be withdrawn or amended and the advertiser must not use the approach again. **3) Reduce the availability of foods that can contribute to an unhealthy diet.** We believe it is important people are equipped with the knowledge and supported to maintain a healthy lifestyle including a balanced diet. Rather than reducing the availability of certain foods we think it is important that people understand the role all foods can play in their diet, from daily staples to occasional treats, as well as realising the importance of portion size and frequency of consumption.	

[21] Foods high in fat, salt and sugars.

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				As the largest manufacturing sector in the UK, we recognise the importance the workplace can have on people's long term health. We firmly believe that responsible employers can provide an environment which facilitates individual action by making it easier for employees to eat a balanced diet and be physically active. Many of our member companies have workplace wellbeing programmes which go far beyond a more traditional health and safety approach, and this is something we consider could be implemented by other sectors, including the public sector. In 2012 we published Workplace Wellbeing, which provides practical guidance for employers on how to create, enhance and promote a health and wellness programme in the workplace. This includes information about encouraging healthy eating and physical activity. We believe the workplace is one of the best areas for bringing together work on calorie consumption, physical activity and education, and should form a key element of any strategy aimed at providing an environment to encourage, enable and reinforce individual actions. **4) Activities to make people aware of what constitutes as healthier food choice** We agree it is important that people are informed about what constitutes a healthy lifestyle and are helped to achieve it. Food labelling plays an important role in improving the food literacy of	

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				consumers, which in turn helps better-informed choices. Our members are committed to continuing to provide clear nutrition information as they implement new labelling requirements under the Food Information to Consumers Regulation. For most packaged food products this means that nutrition information will be a mandatory require ment by the end of 2014. The majority of products will also continue to include voluntary front of pack information, covering energy, sugars, fat, saturates and salt presented on a *per portion* basis against Reference Intakes, the new term for Guideline Daily Amounts (GDAs). As part of our commitment to clear and transparent labelling we have produced a food and drink labelling toolkit aimed at health care professionals to help them explain why it is important to look at food labels to their patients. **Conclusion** FDF believes that food and soft drinks manufacturers have shown real leadership in how they have responded to the debates about complex public health issues. Industry has already demonstrated that much can be achieved through voluntary initiatives, which can move quicker and prove to be more flexible than regulation. We believe the food industry is already an important delivery partner and we are willing to be involved closely in any discussions about how to bring long-term strategy public health strategies to life. We also believe that the food industry is just one in a wide array of partners that are necessary to	

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				implement successful strategies, and so we are pleased to note the breadth of activities NICE are considering.	
Institute of Health and Society, Newcastle University	15.0	General		The guideline discusses how non-communicable diseases can contribute to dementia, disability and frailty and uses CVD, diabetes, COPD and some cancers as examples. The guideline states that it focuses on primary prevention, however weight management through diet and physical activity is a recognised primary prevention strategy for arthritis and yet it is not referred to. Arthritis is not only a physically debilitating and disabling condition but can also result in social isolation. Furthermore, arthritis can lead to further reduction in physical activity and weight gain, thereby exacerbating the risk of developing one or more of the secondary non-communicable diseases already discussed in the guideline.	Thank you for your comment. The guideline makes reference to achieving and maintaining a heathy weight at key points.
Institute of Health and Society, Newcastle University	1.8	Recommendation 8	7	The potential beneficial application of campaigns to disseminate health messages is acknowledged however, as is mentioned later in the guideline (section 4, pg 21) raising awareness is unlikely to be sufficient to motivate behaviour change and this caveat should be highlighted in this section also.	Thank you for your comment. The recommendations should be considered in the context of the whole guideline document.
Institute of Health and Society, Newcastle University	1.3	Recommendations 3-6	5-7	A focus of the guideline appears to be to identify ways to price or shame people out of engaging in particular health behaviours with limited attention to considering finding solutions to underlying problems (linked to financial, psychological and/or social wellbeing). It would be helpful to further acknowledge the individual and social determinants of behaviour and behaviour change in order for policy makers, practitioners etc. to fully recognise the potential and complex barriers	Thank you for your comment. The recommendations emphasise the need to provide an environment that supports healthy behaviours. To that end it includes recommendations at both

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				to such interventions.	population and community level interventions. The latter cover service provision to support healthy behaviours.
Institute of Health and Society, Newcastle University	1.13	Recommendation 13	12	We agree that important life stages or events may be ideal windows of opportunity to intervene and promote a healthier lifestyle and that such times are "when people may consider adopting new healthy behaviours". However, we recommend that this sentence is revised to also include that such life events may also result in behaviour change that was *not* considered (i.e., unintentional) and may be a response to the new situation or environment (social, physical, financial etc). This behaviour change may therefore not be positive.	Thank you for your comment. The risk of adopting unhealthy behaviours has been added in the final guideline.
Institute of Health and Society, Newcastle University	3.0	Context	15-18	Perhaps beyond the remit of this guideline as the dataset is non-UK, but a pooled dataset of Australian longitudinal studies, which explores the influence of smoking, sedentary lifestyle and obesity on cognitive impairment free life expectancy, reports an association between absence of these risk behaviours and longer cognitive impairment free life expectancy, which would support this guideline (Antsey et al; International Journal of Epidemiology, in press).	Thank you for bringing this evidence to our attention. It may inform future updates of the guideline, which will be reviewed for update at 2 years post publication.
Institute of Health and Society, Newcastle University	4.7	4.7 & 4.8		We find the distinction between population and individual-based approaches confusing because all interventions that change or aim to change behaviour must necessarily involve individuals. We recommend clarification of what is meant by a population-based approach and an individual-based approach.	Thank you for your comment. Definitions have been added to the glossary in the final guideline.
Institute of Health and Society, Newcastle University	5.2	5.2		We strongly agree with this research recommendation but feel that it is also important to include the need for research to specifically identify the long-term effectiveness of interventions in mid-life to ensure that	Thank you for your comment. The need for research with long-term follow up has been

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				behaviour change is sustained and therefore has the greatest chance of preventing or delaying dementia, disability and frailty. For example, we found that physical activity and dietary interventions can be effective up to and beyond 12 months in adults of retirement age but data on the cost-effectiveness of such interventions is limited (Hobbs et al 2013, BMC Medicine, 11:75; Lara et al 2014, BMC Medicine, 12**:** 60).	clarified in the final guideline.
Living Streets	15.0	General		We welcome this guidance and the references contained within it to promote walking and improve environments for walking. However, many of the recommendations will require policy changes by central Government in order to enable action by local authorities at the local level.	Thank you for your comment. The Public Health Advisory Committee recognised the significant role that local government will play in implementing this guideline.
Living Streets	1.1	Recommendation 1	4	We welcome recommendation one but would like to see a reference to the links between health and active travel such as walking within the recommendation.	Thank you for your comment. Recommendation 12 in the final guideline makes this link.
Living Streets	1.4	Recommendation 4	5	We recommend that this recommendation be amended to include a reference to the "*maintenance of and new*" traffic management and highway schemes and add the line "*and all new developments such as housing developments*".	Thank you for your comment. The final guideline has been changed to reflect this.
Living Streets	1.7	Recommendation 7	7	Whilst we welcome recommendation 7 we believe the recommendation as drafted places too much emphasis on notices and posters to encourage active travel. We would like to see a broader statement which references the need to promote active travel through public sector organisations through both printed and digital campaigns.	Thank you for your comment. The final guideline has been changed in line with this.

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				Furthermore, promotional activities should also include employee engagement events. For example, Living Streets operates Walk Doctor events with employers to discuss the opportunities to increase the levels of walking undertaken by employees before, during and after work.	
Living Streets	1.7	Recommendation 7	7	This section should reference the Quality Standard – Physical Activity: encouraging activity in all people in contact with the NHS (staff, patients and carers) which is currently under development.	Thank you for your comment. NICE guidelines don't cross reference to Quality Standards. Links between recommendations and NICE quality standards sit in the NICE pathways, visual representations of recommendations in key topic areas.
Living Streets	1.9	Recommendation 9	9	Bullet two of this recommendation should reference the active travel such as walking in addition to "*domestic, leisure and work activities*".	Thank you for your comment. The PHAC did not consider this addition to be necessary as there are specific recommendations for physical activity promotion.
Living Streets	1.14	Recommendation 14	12	Bullet one of this recommendation should also make reference to infrastructure which will support walking such as high quality footways and pedestrian crossings which provide enough time for older people to cross the road.	Thank you for your comment. The final guideline cross references to PH41 Walking and Cycling guideline which makes recommendations

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					about infrastructure.
Living Streets	1.16	Recommendation 16	13	This section should reference the Quality Standard – Physical Activity: encouraging activity in all people in contact with the NHS (staff, patients and carers) which is currently under development.	Thank you for your comment. NICE guidelines don't cross reference to Quality Standards – links between recommendations and NICE quality standards sit in the NICE pathways, visual representations of recommendations in key topic areas.
London Borough of Newham, Public Health Service	15.0	General	all	All recommendations seem appropriate given the importance of the subject i. Prioritisation of implementing this guidance within corporate strategic commissioning plans of LA and CCG operating plans would be necessary ensure implementation ii. Responsibility to be entrusted to the DPH, Adult Social care Director and the CCG Chair (via sub committee with clear accountability) to implement the guidance with a robust action plan and clear accountability. iii. Ensure structured feedback mechanism to the Health & Wellbeing boards on implementing this guidance to highlight any barriers (if any) and to seek advice. iv. Prioritise recommendations to be implemented in a phased manner underpinned by public health needs, inequalities and the impact of proposed interventions v. Resource implication is an issue and suggesting local authorities to	Thank you for your comment.

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				use ring fenced public health budgets (as appropriate) for life style related local interventions	
London Borough of Newham, Public Health Service	1.6	Recommendation 6 1st bullet point (2nd item)	6	Measures to promote "truly healthy food outlets" in place of fast food outlets near schools and work places	Thank you for your comment. The Public Health Advisory Committee (PHAC) have revised the wording in the final guideline to specify the constituents of an unhealthy diet.
London Borough of Newham, Public Health Service	1.8	Recommendation 8 2nd bullet point	8	i. National campaigns to use TV, radio and print media informed by qualitative research prior to develop messages ii. Keep appropriate health related staff informed about the campaign so that they can provide 'cue' to action & reinforce mass media messages. iii. In addition to national TV and radio channels, local newspapers, METRO, Evening Standards and other news letters of LA, CCG to promote the campaign iv Consider including messages aimed at school children particularly on physical activity, food and alcohol so that messages will be communicated to family- parents, uncles and aunts, grand parents (within ethical means)	Thank you for your comment. The final guideline refers to a range of media and formats to reach as many people as possible. Health and social care professionals are included in the recommendation. Children are not included in the scope of this guideline.
London Borough of Newham, Public Health Service	1.9	Recommendation 9 2nd bullet point	9	In developing educational messages, stating the amount of: a. calories that would be spent during common household activity and also leisure activities will be useful, b. calorie content of common food items and also energy dense fast	Thank you for your comment. The Public Health Advisory Committee did not make a recommendation about the

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				food State how much walking has to be done to burn the calories consumed by eating a "Mars" bar (optional)	detailed content of any campaign – this would be determined by the commissioning agency, and could be informed by topic-specific recommendations from other NICE guidelines.
London Borough of Newham, Public Health Service	1.9	Recommendation 9 3rd bullet point	9	**<u>Alcohol</u> (Practical comment)** Consider including following in messages: "how much is a unit of alcohol " as definition varies in different settings". "What are the tips to cut down the alcohol intake"?	Thank you for your comment. Again, the precise wording of campaign messages is not included in the recommendations.
London Borough of Newham, Public Health Service	1.10	Recommendation 10 2nd bullet point	10	For this to be effective it needs to be included in the local enhanced service for NHS health checks with primary care & include a KPI to monitor progress.	Thank you for your comment. The guideline includes a recommendation about the NHS Health Check programme.
London Borough of Newham, Public Health Service	1.10	Recommendation 10 3rd bullet point	10	Prevention programmes i. Support to local authorities (Public Health & adult social care) through provision of the following tools/evidence would be useful to include in the JSNA , funding proposals , business cases etc. a. A commissioning tool to work out how to calculate the costing interventions based on local socio-demographics and inequalities b. Return on investment for specific interventions to convince commissioners to fund programmes	Thank you for your comment. We will pass this information to our Implementation team.
London Borough of Newham,	1.12	Recommendation	11	Areas with a very high proportion of minority ethnic groups, and/or low	Thank you for your comment.

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Public Health Service		12		literacy rate have difficulty in using online tools. Printed materials would be more useful in addition to online versions.	The guideline recommends providing information in a range of formats and as well as addressing language and cultural requirements.
Medical Research Council Institute of Hearing Research	1.0	Overview	1	For the reasons detailed below, we believe that "hearing loss" should be added to the list of "other chronic non-communicable conditions in later life that can contribute to disability and frailty" on the opening page	Thank you for your comment. Hearing loss is included in the definition of non-communicable chronic conditions in the final guideline.
Medical Research Council Institute of Hearing Research	1.0	General: the recommendations		It is disappointing that the clear effect of hearing loss on the prevalence and onset of all-cause dementia is not emphasized in these recommendations. There has been evidence of the involvement of hearing loss for at least 25 years, and new data in the last 3 years makes the case compelling: • "we observed a dose-response relationship in which greater hearing loss was associated with a higher adjusted relative odds of having dementia." (100 cases, Ulman et al 1989: JAMA 261:1916-9.). • "Compared with normal hearing, the hazard ratio (95% confidence interval) for incident all cause dementia was 1.89 (1.00-3.58) for mild hearing loss, 3.00 (1.43-6.30) for moderate hearing loss, and 4.94 (1.09-22.40) for severe hearing loss." … "Hearing loss is independently associated with incident all-cause dementia. Whether hearing loss is a marker for early-stage dementia or is actually a modifiable	Thank you for bringing this evidence to our attention. We did search for published evidence on this in relation to hearing and hearing loss when developing the evidence review, but found very little. We then sought expert testimony on mid-life interventions to prevent later hearing loss, and this was considered by the Public Health Advisory Committee (PHAC) (please see Expert paper 10.) The final guideline represents what the PHAC

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				risk factor for dementia deserves further study." (639 cases; Lin et al 2011, Archives of Neurology 68: 214-220). • "Elderly individuals with HL have an increased rate of developing dementia and more rapid decline on 3MS-R scores than their non-hearing impaired counterparts. These findings suggest that hearing impairment may be a marker for cognitive dysfunction in adults age 65 years and older" (836 cases; Gurgel et al 2014, Otology & Neurology 35:775-81)	felt they were able recommend on the basis of the available evidence. A research recommendation is made in this area (Please see section 5.4 in the final guideline).
Medical Research Council Institute of Hearing Research	1.0	The Recommendations	4	It is somewhat surprising that smoking and drinking feature so heavily in the recommendations given that a study organized by the UK Medical Research Council failed to find any substantial predictive or protective effect between these factors and the development of dementia (Yip et al 2006, Age Ageing, 35:154-160)	Thank you for your comment. The guideline focuses on the prevention of disability and frailty as well as dementia. A range of evidence published since the 2006 paper cited here was considered by the Public Health Advisory Committee, this can be viewed here.
Medical Research Council Institute of Hearing Research	1.0	The Recommendations	9	We believe that the data is strong enough for the text "Visual and hearing loss are associated with social isolation and can be a barrier to changing behaviour and using services" to be changed to "Visual and hearing loss are associated with dementia and social isolation. They are a barrier to changing behaviour and using services"	Thank you for your comment this bullet has been removed from the final guideline due to the lack of intervention evidence in the mid-life age group. The information about the potential link is in consideration 4.24 in the

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
					final guideline.
Medical Research Council Institute of Hearing Research	5.0	Recommendations for Research (Section 5)	27	The data cited above appear quite unequivocal and have become very influential in just a short space of time. If included in the materials considered they would have had a significant impact on these Guidelines. However, the studies were conducted in the USA, and it appears that, quite understandably, to limit the huge amount of relevant literature, a decision was made to include only data from UK population samples. Given their importance, however, their omission from consideration is unfortunate and weakens the recommendations. We therefore argue that there should be two additional "recommendations for research": • large scale studies of hearing and dementia on the UK population; • are interventions for hearing loss effective in delaying the onset of dementia? We note that the Draft guidelines comment on the lack of research into hearing: "Only a limited amount of vision and hearing loss literature was found that reported dementia, disability and frailty outcomes" (p 23, section 4.20),	Thank you for your comment. Hearing and visual loss are included in the research recommendation 5.4 in the final guideline.
Medical Research Council Institute of Hearing Research	11.0	Gaps in the Evidence	44	The Gaps explicitly state that "There is a lack of evidence on the effectiveness and cost-effectiveness of interventions to prevent and manage hearing and visual loss on the development of dementia" (p	Please see previous response.

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				44). This confirms the need to include new research on hearing loss and dementia into the "Recommendations for Research" section	
National Institute for Health Research Clinical Research Network: Ear, Nose and Throat Specialty	1.10	1	10	Recommendation 10: Addressing hearing loss amongst the mid-life population would have the benefit of preventing: a) the social isolation and; b) barriers to accessing health and care services that people with hearing loss can encounter. If it is proven that the link between hearing loss and decreased cognitive function is causative, then the early amelioration of decline in hearing could prevent or slow the development of dementia in older people. We therefore believe that monitoring people for hearing loss should be included in the disease prevention programmes and NHS Health Checks, and that the importance of such monitoring should be emphasised to the stakeholders listed in this Recommendation.	Thank you for your comment. The content of the NHS Health Check Programme is the remit of Public Health England. The Expert Scientific and Advisory Panel for NHS Health Check has a developed a content review process that would have to be followed to make changes to the content. Amending or introducing new content may require the approval of the government.
National Institute for Health Research Clinical Research Network: Ear, Nose and Throat Specialty	1.11	1	10	Recommendation 11: The stakeholders listed in this Recommendation should be made aware that the provision of audiological screening should be considered to be a service which can help to prevent disability and potentially dementia.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not feel that there was sufficient evidence to make this

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					change.
National Institute for Health Research Clinical Research Network: Ear, Nose and Throat Specialty	1.15	1	13	Recommendation 15: It should be stated that one of the risk criteria for people at risk from dementia is hearing loss, as it has been shown that people with hearing loss have a greater risk of developing dementia or Alzheimer's disease.	Thank you for your comment. The final guideline represents what the PHAC felt they were able recommend on the basis of the available evidence.
National Institute for Health Research Clinical Research Network: Ear, Nose and Throat Specialty	3.0	3	16	We are pleased to see that it has been acknowledged: a) that hearing loss affects a significant proportion of people over 50 in the UK; and b) that people with hearing loss have a greater risk of developing dementia or Alzheimer's disease.	Thank you for your comment.
National Institute for Health Research Clinical Research Network: Ear, Nose and Throat Specialty	4.0	4	23	In 4.20, the meaning of the following sentence is unclear: "This is relevant to this guideline because vision and hearing problems are risk factors for dementia, disability and frailty because they affect people's ability to be involved in their own medical care." The sentence could imply any of the following: a) vision and hearing problems are risk factors for dementia, disability and frailty; b) vision and hearing problems affect people's ability to be involved in their own medical care c) dementia, disability and frailty affect people's ability to be involved in their own medical care d) something that affects people's ability to be involved in their own medical care is a risk factor for dementia, disability and frailty.	Thank you for your comment. This consideration has been changed in the final guideline (Please see section 4.25).

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				This point should be re-written to improve clarity.	
National Institute for Health Research Clinical Research Network: Ear, Nose and Throat Specialty	11.0	11	44	Points 5-7 The sphere of ENT medicine encompasses hearing loss, elements of sleep disorders and balance problems (which can result in falls). The lack of evidence available to determine the cost-effectiveness of monitoring and treating such problems in mid-life, in order to reduce rates of dementia, disability and frailty in later life, should provide a strong impetus to carry out research in these areas. This would allow an evidence base to be developed.	Thank you for your comment. The lack of evidence about the impact of interventions in mid-life on the prevention of falls is included in the guideline.
National Voices	15.0	General		Overall, we welcome the guideline's broad target audience which highlights the role of a wide range of partners in this important agenda. We believe that prevention increasingly needs to be a central part of all health and care professionals' work, but all too often it is seen as an 'add on' or something dealt with elsewhere in the system. The Care Act 2014 has gone some way to promoting this change in focus as part of a holistic approach in social care but alternative mechanisms in health (e.g. the unplanned admissions DES) have taken a more tick box approach. We were particularly pleased to see the role of the voluntary and community sector acknowledged throughout the guideline. The sector's proximity to disadvantaged groups can help to ensure that any prevention focussed interventions can benefit all sections of the local population. We also welcome the recognition that there are steps that can be	Thank you for your comments.

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				taken to reduce the likelihood of ill health in old age, and the role that individuals play in establishing and maintaining healthy behaviours. Health cannot be 'done to' people. It is vital that individual and population level interventions are tailored in a way that is meaningful and relevant to the person or group of people, and that they are connected to support within the community which enables them to sustain positive changes over time.	
National Voices	15.0	General		National Voices has published a series of short guides which brought together the evidence from 779 systematic reviews to illustrate which interventions can enable more person-centred coordinated care. These were published in June and so may not have been included in the initial trawl of evidence. http://www.nationalvoices.org.uk/evidence This resource includes a short guide on promoting prevention which might be of interest in relation to this guideline: http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/promoting_prevention.pdf Many of the interventions included are already referenced but we would welcome increasing recognition of the role of peer support in supporting self-management where people already have existing conditions, and enabling people to make and maintain healthier choices and behaviour. The results of one of the largest randomised control trial conducted	Thank you for your comment. This document was published after the evidence reviews were completed. It is not clear from the link provided what methods were used to select, appraise and synthesise the evidence, nor which populations are the focus. The scope for this guideline sets out the evidence and areas which were considered during development. The literature searches for the evidence reviews which informed this guideline were broad and detailed, and the final recommendations represent

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				around peer support in diabetes by Cambridge University hospitals indicated significant improvement in blood pressure, a key determinant of stroke and heart attacks which is likely to lead to 2-4% reductions in mortality. Our member, Diabetes UK, has now developed a new service to respond to these findings. More information on this is available here: http://www.slideshare.net/NESTA_UK/patient-power-learning-about-peertopeer-healthcare-workshop-5	what the Public Health Advisory Committee felt they were able to say on the basis of the available evidence. Thank you for your comment. The guideline focuses on primary prevention.
National Voices	15.0	General		National Voices has also been working with a wide range of stakeholders to develop 4 substrands of its previous work on the Narrative for person centred coordinated care: http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf A forthcoming substrand on the experiences of older people looks specifically at the issues of independence, social interactions, decision making and care and support. More information on this work can be found here: http://www.nationalvoices.org.uk/take-part-research-about-what-matters-most-older-people	Thank you for your comment. The guideline focuses on primary prevention. You may also be interested in NICE guideline in development on older people: independence and mental wellbeing.
National Voices	15.0	General		Due to it being an individual-focused intervention, the relevance of care and support planning as a preventative approach across a cross section of a local population is often neglected. Where a person already has a condition or is at risk of deterioration (as per the focus on the older, more 'vulnerable' population under the Transforming Primary Care agenda), care and support planning can act as a gateway to many of the interventions that can enable a person	Thank you for your comment. The guideline focuses on primary prevention but we acknowledge the role of secondary prevention.

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				to become more informed and confident about taking decisions and action about their health and wellbeing (e.g. shared decision making and support for self-management). It can also connect them into community resources that can continue to build their knowledge and resilience over time. Ensuring that people have access to this approach earlier on in their lives will increase the likelihood of sustainable behavioural change, enabling people to better manage existing conditions, and potentially prevent or delay the development of additional or related conditions which may lead to disability and frailty. National Voices has developed a guide which sets out what good care and support planning should look like (http://www.nationalvoices.org.uk/what-care-and-support-planning) and has more recently been working with NHSE and colleagues to develop some guidance to support commissioners and providers to make use of such approaches in their local areas. This is due to be published in the autumn.	
National Voices	15.0	General		It would be good to ensure that the guidance is completely consistent in relation to its recommendations on alcohol. In some places it suggests that it is acceptable to drink in moderation, whereas other sections (e.g. 4.32 or under recommendation 9) suggest that there is no safe level of alcohol consumption.	Thank you for your comment. The wording has been revised in the final guideline.
National Voices	1.8	1	8	It would be useful to recognise the role of the voluntary sector in	Thank you for your

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				supporting national agencies to engage with high risk communities to develop a better understanding of what campaign materials would speak to them.	comment. The voluntary sector is included in the guideline as part of the 3rd sector.
National Voices	2.0	2	14	We agree with the comments that the document may be of interest to people in or approaching mid-life and their families, and other members of the public, but would like to highlight that this would need to be made available in an easier to read format to ensure that everyone can benefit from the information it contains. Also, if looking to promote these messages to a more public audience, our work on the Narrative has indicated that people do not tend to self-identify with the word 'frailty'.	Thank you for your comment. The documents are written for professionals. NICE guidelines are also made available via the Pathways facility on our website.
National Voices	5.3	5.3	28	We welcome the research recommendation in relation to the role of psychosocial risk factors. The vital importance of maintaining community interactions to avoid social isolation was something that came out strongly throughout the development of our older people's Narrative (draft referenced above).	Thank you for your comment.
NHS England	15.0	General		Thank you for the opportunity to comment on the above Public Health Guideline. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.	Thank you for your comment.
NIHR Nottingham Hearing Biomedical Research Unit	1.0	Draft Recommendations:	8-9	We have reviewed the 19 recommendations put forward by the report. We are pleased to note that part of Recommendation 9 includes information and advice provided by National government, Public	Thank you for your comment. This text has been moved to the considerations section in

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
		General		Health England and NHS England on how i) psychosocial factors, such as loneliness and isolation are associated with the development of cognitive decline and dementia and ii) vision and hearing loss are associated with social isolation and can be a barrier to changing behaviour and using services. However, we do not believe that the recommendations go far enough. First the report overlooks the crucial need for further research to establish whether or not the social isolation associated with sensory loss is the primary mediator for cognitive decline and dementia. With respect to point (ii), the NICE guidance draft implies that the impact of hearing loss on dementia is mediated via psychosocial factors such as social withdrawal and isolation. While evidence indicates that individuals with hearing loss are more likely to have a diagnosis of dementia (Uhlmann et al., 1989; Ives et al. 1995) and poorer cognitive function (Cacciatore et al., 1999), **the mediating factors have not yet been firmly established by evidence**. It may or may not be attributable to psychosocial factors. At present another plausible alternative explanation for the observed relationship is that hearing loss and progressive cognitive impairment are caused by a common neuropathologic process, possibly the same that leads to Alzheimer disease, or common vascular disease or factors related to family history (e.g., apolipoprotein E [ApoE] status) (Lin et al., 2011). More recently there has been there has been evidence from MRI scans that people with hearing loss have accelerated brain atrophy (Lin *et al.* 2014). These have yet to be fully elucidated. We would propose that this forms a recommendation for future research.	the final guideline. Thank you for your comment. The guideline template restricts the number of research recommendations. The research recommendations therefore are those identified by the advisory committee as priorities.

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				Second with respect the recommendations, **there is no current recommendation to those who commission services** (such as Clinical Commissioning Groups) to ensure provision for those interventions for vision and hearing losses. There is a real threat that CCGs might decommission hearing services within the NHS. In particular, North Staffordshire Clinical Commissioning Group has recently proposed that hearing aids no longer be provided to those with "mild to moderate age-related hearing loss". This proposal is currently under consultation (see http://www.northstaffsccg.nhs.uk/hearing-aids) despite the evidence that hearing aids are the most common form of intervention known to significantly reduce the functional impacts of hearing loss (Chisolm *et al.* 2007). There is also substantial evidence that those fitted younger than the average age (typically 70 years) gain greater benefit from hearing aids that those of the same age and hearing loss fitted later (Davis *et al.* 2007). Cacciatore F, Napoli C, Abete P, Marciano E, Triassi M, Rengo F. (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology. 45(6): 323-328. Chisolm, T. H., Johnson, C. E., Danhauer, J. L., et al. (2007). A systematic review of health-related quality of life and hearing aids: final	Thank you for your comment. The Public Health Advisory Committee (PHAC) noted your concern. It heard expert testimony on hearing loss (please see Expert paper 10.) but felt unable to make a recommendation due to the lack of evidence of a preventative effect. Thank you for your comment. Please see previous response.

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				report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults. *Journal of the American Academy of Audiology, 18*, 151-183. Davis, A., Smith, P., Ferguson, M., et al. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *Health Technology Assessment, 11*. Ives DG, Bonino P, Traven ND, Kuller LH. (1995). Characteristics and comorbidities of rural older adults with hearing impairment. *J Am Geriatr Soc*. 43(7):803-806. Lin F.R., Metter E.J., O'Brien RJ, Resnick SM, Zonderman AB, Ferrucci L. (2011). Hearing loss and incident dementia. Arch Neurol. 68(2):214-220 Lin, F., Ferrucci, L., An, Y., et al. (2014). Association of Hearing Impairment with Brain Volume Changes in Older Adults. *NeuroImage, 90*, 84-92. Uhlmann RF, Larson EB, Rees TS, Koepsell TD, Duckert LG. (1989). Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. *JAMA*. 261(13):1916-1919.	

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NIHR Nottingham Hearing Biomedical Research Unit	1.0	Section 1-16: Recommendations	4-13	The focus of the recommendations is on lifestyle choices and long term conditions such as cardiovascular disease and diabetes. However, hearing loss as a long term condition is referenced on only a few occasions, despite the growing evidence that **hearing loss is associated with dementia with those having mild, moderate, and severe hearing loss having a 2-, 3- and 5- times risk of developing dementia** (Lin *et al.* 2011), highlighted in the annual report of the Chief Medical Officer (Davies 2014). Hearing loss affects 1 in 6 of the UK population, affecting 10 million people, and with the increasing ageing society is set to affect 14.1 million by 2030, affecting 14.8% of the population (AoHL 2011). It is currently estimated to be the 13th most common disease burden worldwide and it is predicted by 2030 to be the seventh most common. Hearing loss results in communication difficulties that lead to social isolation and withdrawal (recognised in recommendation 9) as well as employment difficulties (estimated to lead to loss in potential economic output to the UK economy of £24.8bn, rising to £38.6bn in 2030 (Greengross 2014)) and increased of dementia. Although the effects are substantial to the individual, society and the economy, the research evidence on interventions is limited compared to other LTCs. For example in the UK funding for research into hearing loss was just £1.34 for every person affected. This compares to £14.21 for sight loss, £21.31 for diabetes, and	Thank you for your comment. The Public Health Advisory Committee (PHAC) noted your concern. It heard expert testimony on hearing loss but felt unable to make a recommendation due to the lack of evidence of a preventative effect.

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				£49.71 for cardiovascular research (AoHL, 2011). We would like to see a greater emphasis put on hearing loss and its links with dementia in the guidelines to raise awareness of the associations between the two and to encourage and promote further research on these important topics. AoHL. (2011). Hearing Matters. In (pp. 1-84): Action on Hearing Loss. Davies, S. C. (2014). Annual Report of the Chief Medical Officer Surveillance Volume, 2012: On the State of the Public's Health. In. London: Department of Heath. Davis, A., Smith, P., Ferguson, M., et al. (2007). Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health Technology Assessment, 11, 1-294. Greengross, S. (2014). Commission on Hearing Loss: FInal Report. In I. L. Centre-UK (Ed.), (pp. 1-38). London. Lin, F., Ferrucci, L., An, Y., et al. (2014). Association of Hearing Impairment with Brain Volume Changes in Older Adults. NeuroImage, 90, 84-92. Lin, F. R., Metter, E. J……O'Brien, R. J., et al. (2011). Hearing Loss and Incident Dementia. Archives of Neurology, 68, 214-220.	
NIHR Nottingham Hearing Biomedical Research Unit	4.20	Section 4.20; The Evidence	23	We are pleased to note that the guideline highlights the rather limited amount of evidence for the effect of vision and hearing loss on reported dementia, disability and frailty outcomes, and for the effect of mid-life interventions on preventing the loss – or the functional impact of the loss. However, we do not believe that this point goes far enough	Thank you for your comment. A research recommendation has been included in the final guideline.

Stakeholder Organisation		Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				since there **is no specific research recommendation to address these issues**. The guidelines therefore miss an opportunity to encourage and promote further research on these important topics.	
NIHR Nottingham Hearing Biomedical Research Unit	5.0	Section 5; Recommendations for Research	28	We are pleased to note that the guideline highlights the rather limited amount of evidence for the effect of vision and hearing loss on reported dementia, disability and frailty outcomes, and for the effect of mid-life interventions on preventing the loss – or the functional impact of the loss. However, we do not believe that this point goes far enough since there is **no specific research recommendation to address these issues.** The guidelines therefore miss an opportunity to encourage and promote further research on these important topics.	Thank you for your comment. Please see previous response.
NIHR Nottingham Hearing Biomedical Research Unit	11.0	Section 11; Gap in Knowledge	44, paragraph 5	The draft guidance correctly points to a lack of evidence of effectiveness and cost-effectiveness of auditory prostheses in arresting cognitive decline in older individuals. The critical question: does appropriate management of a hearing loss reduce, delay or modify the risk of later cognitive decline? – remains unanswered. This requires carefully designed, randomised, prospective controlled clinical trials to address this important gap in knowledge and to better understand the underpinning pathways linking hearing loss and cognitive decline. The UK is particularly well positioned to address such questions as the hearing research community and its voluntary sector has a long track record of undertaking seminally important population studies on hearing loss and its cognitive sequelae. This gap in knowledge is recognised in a recent Editorial in *Aging and Mental Health* (Lin et al., 2014) and such studies are about to begin in the US supported by the	Thank you for your comment. A research recommendation has been included in the final guideline.

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				National Institutes of Health. Lin F, Albert M, Hearing Loss and Dementia – who is listening? Aging and Mental Health. 2014; 18 (6) 671 -3.	
A research Oxford Project to Investigate Memory and Ageing (OPTIMA)	15.0	General		This is a really outstanding document. I am impressed by the content, which is very important, and by the excellent and clear way it is written.	Thank you for your comment.
Oxford Project to Investigate Memory and Ageing (OPTIMA)	3.0	Section 3	17	This is the only place where high blood pressure is mentioned in the whole document. Here it is given as one of 7 health risk factors in mid-life identified by the Chief Medical Officer. Whereas most of the other risk factors are later related to increased risk of dementia, there is no mention of hypertension. I find this very surprising since there is a lot of observational evidence that hypertension in mid-life is a major risk factor for later dementia. See Launer LJ et al. Lowering midlife levels of systolic blood pressure as a public health strategy to reduce late-life dementia: perspective from the Honolulu Heart Program/Honolulu Asia Aging Study. *Hypertension* 2010;55(6):1352-9. Mid-life hypertension was, for example, listed as one of 8 risk factors for Alzheimer's disease in the analysis by Barnes & Yaffe (*Lancet Neurol.* 2011; 10: 819. So far, all of the trials on this topic have been done on elderly subjects and have also not been ideal, as pointed out in the Cochrane review (McGuinness B, et al. Blood pressure lowering in patients without prior cerebrovascular disease for prevention of cognitive impairment and dementia. *Cochrane Database Syst Rev* 2009(4):CD004034. What is needed are trials in mid-life with long follow-up. Nevertheless, I do feel that attention should be drawn to the need to treat hypertension in mid-	Thank you for your comment. As detailed in scope, this guideline covers primary prevention.

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				life as one of the likely risk factors for later dementia and disability. Hypertension is of course a major risk factor for stroke and stroke-related dementia is common.	
Oxford Project to Investigate Memory and Ageing (OPTIMA)	1.3	Section 1; 2	12, 15	I can only find reference to General Practice in Recommendation 13. Surely, it should appear specifically in the Table on page 15? GPs and practice nurses have a key role to play in disseminating the message because they are the medical professionals seen most frequently by the public and they are well respected. More emphasis should be given to their role.	GPs and practice nurses are included in the table as part of health services.
Public Health England	15.0	General	N/A	Public Health England (PHE) welcomes this draft public health guideline on approaches in mid-life to prevent or delay dementia, disability and frailty. PHE would be happy to provide any further information to support the development of the guideline prior to publication. In the meantime, we have the following comments on the draft.	Thank you for your comment.
Public Health England	15.0	General	N/A	PHE welcomes the recommendations in the draft public health guideline. PHE has made dementia risk reduction a priority area of work and is working with system partners to identify a range of actions which could significantly reduce the risks and the impact of dementia. Dementia risk reduction can bring significant benefits to individuals. Shared risk factors mean that by reducing their risk of dementia, people can also reduce their risk of stroke, heart disease, diabetes, and a range of other conditions. This will enable people to lead longer lives with less illness and disability.	Thank you for your comment.
Public Health England	15.0	General	N/A	PHE worked with the UK Health Forum to develop and publish the	Thank you for your comment.

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				Blackfriars Consensus on brain health in May 2014. The Consensus has been signed by 28 national organisations, 32 individuals and the 5 ministers with lead responsibility for health in England, Wales, Scotland and Northern Ireland. The Consensus states that on the available evidence there is more that we could and should be doing to reduce the risk of dementia in the population. It would be helpful for the public health guideline on approaches in mid-life to prevent or delay dementia, disability and frailty to refer to the Blackfriars Consensus.	
Public Health England	15.0	General	N/A	The Blackfriars Consensus states that the evidence now clearly points towards concerted action to address lifestyle risk factors for dementia, which include tobacco, poor diet, physical inactivity, and alcohol but it also refers to action in relation to people with existing conditions that increase their risks of dementia, as well as promoting protective factors (such as social engagement). The draft guideline's recommendations largely focus on lifestyle risk factors and it would be helpful for the final guideline to also consider recommendations relating to the identification and support individuals already at higher risk of dementia and other non-communicable diseases through diagnosis and management of pre-disposing conditions including high blood pressure, stroke and type 2 diabetes as well as the prevention of depression, through wellbeing strategies and interventions.	Thank you for your comment. As defined in the scope, this guideline focuses on primary prevention.
Public Health England	15.0	General	N/A	While the focus of the guideline is mid-life approaches, there are few mentions of specific age groups in the draft guideline. Including indications of where evidence supports interventions with people at specific age ranges could be helpful to those implementing the	Thank you for your comment. The evidence does not support any further detail about age range. The

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				recommendations. Where the evidence is unavailable to support such references, the final guideline could helpfully include this area within the recommendations for research. It would also be helpful to note that effective preventative approaches for life-long health start in early years.	importance of a life course approach is acknowledged recommendation 4
Public Health England	1.1	Section 1	4	The draft recommendations (1 & 2) for PHE and other national agencies to develop population-level initiatives and include risk reduction for dementia, disability and frailty in national policy activities and documents aimed at preventing other non-communicable chronic diseases is in line with PHE's plans in relation to dementia risk reduction.	Thank you for your comment.
Public Health England	1.2	Section 1	5	The draft recommendation (2, bullet point 3) for PHE to 'ensure those with a responsibility for public health in local authorities and the NHS understand the regulatory options and local legal powers available to them when developing and implementing population-level initiatives' needs further consideration. While PHE can encourage and work with partners in relation to understanding regulatory powers, PHE cannot ensure these are adopted.	Thank you for your comment. The wording has been changed in the final document. Consideration 4.8 acknowledges the ongoing work of Public Health England.
Public Health England	1.3	Section 1	5-6	The draft recommendations (3 and 5) for PHE and other national agencies to continue to develop and enforce comprehensive tobacco control strategies and to ensure policies to reduce alcohol consumption are implemented across the population are welcomed are in line with PHE's plans in these areas.	Thank you for your comment.

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Public Health England	1.6	Section 1	6	Through the draft recommendation (6) for PHE and national and local government to introduce a national framework for action to help people adopt and maintain a healthy diet, PHE welcomes NICE confirmation that eatwell messages are important for a healthy lifestyle. While taken together as dementia, disability and frailty we agree that healthier diets may be associated with better outcomes. We note the importance in improving diet and lifestyle once conditions such as dementia are established as that may reduce the risk of other conditions (such as fragility) or confounders such as infections that may make symptoms such as confusion worse. However, this draft recommendation includes a range of specific actions on foods whose association specifically to dementia is unclear. PHE has already committed action in *Sugar reduction – responding to the challenge* that will review these areas and it would be premature to conclude these actions at this time. PHE already communicates healthy lifestyles through various routes including our flagship Change4Life social marketing activities.	Thank you for your comment. The recommendation covers the prevention of non-communicable diseases such as CVD and type 2 diabetes, which contribute to the development of disability and frailty.
Public Health England	1.10	Section 1	10	In relation to the draft recommendation (10, bullet point 2) for PHE to develop the NHS Health Checks programme to promote opportunities in mid-life to reduce the risk of dementia, disability and frailty. PHE welcomes recommendation and is working to include dementia risk reduction as a key outcome in all existing and new PHE health improvement programmes, including the NHS Health Check. PHE is also working with local authorities to ensure that the existing dementia element of the NHS Health Check has been implemented locally and to increase uptake of the NHS Health Check programme and referral	Thank you for your comment. A new consideration (4.36) has been added that acknowledges the process to be followed when considering changes to the NHS Health Check content.

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				to appropriate risk management services. The recommendation to extend the dementia component would need to be considered by the NHS Health Check Expert Scientific and Clinical Advisory Panel, who are responsible for advising the Department of Health on any content changes to the programme. We would therefore welcome NICE to recognise this process as part of its recommendation.	
Public Health England	1.7	Section 1	7	Recommendation 7 (final bullet) eatwell dietary guidance has been the remit of PHE since April 2013 as such PHE utilise these messages throughout our advice and guidance. You may therefore wish to amend this recommendation.	Thank you for your comment. The final guidance does not refer to specific examples.
Public Health England	1.9	Section 1	9	Recommendation 9 (third bullet) PHE is already active in communicating messages on diet and related ill health through all its communications including the Change4life social marketing campaign. We are also developing a new campaign approach targeting adults with on demand digital and these messages are already communicated within the NHS Health Checks programme.	Thank you for your comment. Consideration 4.8 acknowledges the ongoing work of Public Health England.
Public Health England	1.15	Section 1	13	Recommendation 15 (page 13, first sentence). This could include community and faith leaders as an additional group which supports workplace health.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider this addition necessary.
Public Health England	3.0	Section 3	16	Context (page 16, third paragraph). While the low income diet and nutrition survey highlighted that those in the lowest 15% income bracket had dietary problems which would impact on health, these	Thank you for your comment. This example has been removed from the final

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				were not greatly different from those seen in the general population but are more pronounced (National Diet and Nutrition Survey, NDNS). NDNS reports that older people tend to have healthier diets than other population groups. As such, the statement that those who are unemployed or have retired early possibly leading to lower quality diet may be too strong. While plausible, we are unclear that this is demonstrable within the literature especially as there are likely to be a range of other confounders that do not seem to have been noted.	guideline.
Public Health England	3.0	Section 3	16	Context (page 16 fourth paragraph) As paragraph 3 in this section, the EPIC and Whitehall studies also have a range of confounders, which may also be relevant in assessing this conclusion which may be somewhat strong.	Thank you for your comment. The Public Health Advisory Committee (PHAC) reviewed your comment, however they are satisfied with the wording.
Public Health England	3.0	Section 3	18	Section 3 (page 18) refers to lower educational attainment as a risk factor for dementia. NICE PHAC should consider including a recommendation aimed at national government and local authorities around improving educational access and opportunities for specific groups in the population who we know are at higher risk due to their lower educational attainment.	Thank you for your comment. While educational attainment has been identified as a risk factor no causal evidence has been identified.
Public Health England	4.33	Section 4.33	27	Section 4.33 (page 27) mentions “Alcohol action teams”. Is this a reference to hospital based Alcohol Care Teams? This is just a minor point of clarification. Although this guideline is about “approaches to prevention”, the guideline would benefit from including advice from NICE CG 100 - ALCOHOL USE DISORDERS: DIAGNOSIS AND	Thank you for your comment. The consideration refers mainly to Alcohol Action Teams in the community. The guideline

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				CLINICAL MANAGEMENT OF ALCOHOL-RELATED PHYSICAL COMPLICATIONS. Chapter 2.7 on page 89 details the treatment and management of Wernicke's encephalopathy – a form of alcohol-related dementia. Alcohol-related dementia looks like other forms of dementia and can only be detected by clinical assessment and history taking to determine the level of alcohol use and involvement in the individuals condition BUT alcohol related dementia, if detected early (could be viewed as early intervention / prevention) can be halted or reversed with abstinence from alcohol and vitamin therapy.	focuses on primary prevention so the treatment of alcohol related dementia is not part of the scope.
Royal College of General Practitioners	1.13	1 Draft recomendations Recommendation 13 AND 9 Summary of the methods used to develop this guideline	12 and 36	When a patient with a strong family history of dementia consults a GP, they are almost bound to ask about the value of food supplements. Moreover, screening for early cognitive decline before asking for a second opinion includes checking for folate and B12 deficiency. The decision to specifically exclude any reference to research in this area from guidelines (a brief reference with a link to some source of detailed evidence at least?) seems odd to me as an experienced GP.	Thank you for your comment. Due to the size of the referral from the Department of Health it was necessary to focus down the interventions included. In this instance it was considered that food supplements would be part of a clinical intervention rather than a public health intervention.
Royal Pharmaceutical Society	15.0	General		The Royal Pharmaceutical Society welcomes public health guidance on approaches in mid-life to prevent or delay dementia, disability and frailty and agrees with the recommendations made. Pharmacists have a significant role in public health, raising awareness of the health risks associated with smoking, alcohol, sedentary	Thank you for your comment.

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				behaviour, unhealthy diet and being overweight and in providing advice on healthy lifestyles. The RPS have developed Professional Standards for Public Health (http://www.rpharms.com/unsecure-support-resources/professional-standards-for-public-health.asp?) to help lead, support and develop pharmacists and pharmacy teams across Great Britain to enable delivery of high quality public health services.	
Royal Pharmaceutical Society	1.13	Recommendation 13	12	The examples given for routine appointments and contacts could include 'when attending community pharmacies'. Pharmacies are accessible, open long hours and present in communities across the country (including areas of deprivation). The accessible and inviting environment of pharmacies in the community, allow people to seek advice at a time that is convenient for them, without having to make an appointment.	Thank you for your comment. Pharmacists are included in the audience for this recommendation under health and social care professionals in the table in section 2.
Somerset County Council	15.0	General		Perhaps it would be useful to have a bit more background on dementia and types of dementia as some organisations the guidance is aimed at may not be particularly knowledgeable and/or the public. Although 4.1 does acknowledge differences the public are often confused between dementia/ Alzheimer's etc.	Thank you for your comment. Some extra text about dementia has been added to section 3 in the final guideline however the guideline template limits the amount of information that can be given.
South West Yorkshire Partnership NHS Foundation Trust	1.1	Recommendation 1 ,	4	Re; Making drinking alcohol less acceptable ; I cannot see how this can be done when the images in media around us show that drinking alcohol is socially acceptable Whilst the" 3 A"s apply to smoking ; only the first 2 apply to alcohol;	Thank you for your comment. The Public Health Advisory Committee felt that the available evidence does not

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				alternatively I would suggest that the the wording is amended so that the 3"A"s apply to alcohol excess or harmful drinking.	support this change.
South West Yorkshire Partnership NHS Foundation Trust	4.32	4.32	27	Re: The expert testimony suggested that there is no safe level of alcohol consumption. There is some evidence to indicate that alcohol lowers the risk of cardiovascular disease if consumed in moderation ; this is a view widely held and would run counter to the statement above and create confusion for the populace. However, the above statement is true for pregnant women and explicitly emphasised.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not make this change as there is a linear relationship for alcohol consumption and the development of some cancers.
Sustrans	15.0	General		Sustrans welcomes this guidance and is grateful for the opportunity to offer comment. As ever, we have restricted our comments to our central area of expertise, physical activity and active travel.	Thank you for your comment.
Sustrans	15.0	General		We would like to pick out one particular issue in England, relevant to this and to other public health guidance. NICE consistently makes recommendations aimed at local government, for example around the environment as a determinant of behaviour and how it can be made more conducive to physical activity. However, much of the funding allocated from central government to local areas is now effectively steered by Local Enterprise Partnerships. Funds from DfT, for example, are packaged up within the Local Growth	Thank you for your comment. Local Enterprise Partnerships have been added to the list of organisations who should take action.

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				Fund, and allocated on the basis of Strategic Economic Plans submitted by the LEPs. LEPs have a narrower range of responsibilities than local authorities, being primarily focused on economic development, and in the field of transport investment there is a risk that they may overlook the health, social and economic benefits achievable by investing in active travel infrastructure. (This might also be true in other fields, although Sustrans is not competent to assert this: NICE might want to investigate). In view of this, you may wish to consider rewording at some points across the guidance, to acknowledge that local decision making is now more complicated.	
Sustrans	15.0	General	Page 1	We are glad to see the focus on behaviour change and a list of co-benefits at the beginning of the guidance.	Thank you for your comment.
Sustrans	1.0	Section 1	Pages 1 - 14	Sixteen recommendations is a lot, and there appears to be some overlap between certain of them. We foresee that you may end up amalgamating some of these. If so, it is important that existing clear messages within the current draft are not lost. Particularly important in our field are: • the environment as a determinant of behaviour and the need for action to address it, as well as motivational approaches • the co-benefits in tackling other forms of NCD, achievable from	Thank you for your comment. The Public Health Advisory Committee (PHAC) considered the content and structure of the guidelines when finalising it.

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				the promotion of physical activity to protect against dementia.	
Sustrans	1.1	Recommendation 1	Page 4	This recommendation is good. We note and support the reference to legal and regulatory frameworks. But we have one comment: it should be clear that the 'national and local government departments with a responsibility for public health' include not just DH and local Public Health teams, but also DfT / Transport, CLG / Planning, DfE / Education, and DWP. All of these sectors have a role to play.	Thank you for your comment. The Public Health Advisory Committee (PHAC) recognise the role that many local government departments play in contributing to public health, however roles and responsibilities may vary locally, and the recommendation as written does cover all of the departments mentioned here.
Sustrans	1.2	Recommendation 2	Page 5	We are glad to see the mention of Healthy Places, an increasingly useful resource.	Thank you for your comment.
Sustrans	1.4	Recommendation 4	Page 5	In our view the organisations seen as relevant should be not only from physical activity and road safety (though we do welcome your awareness of the latter). They should also include sustainable transport, and perhaps also planning, development and architecture.	Thank you for your comment. These groups are included in Section 2 for this recommendation.
Sustrans	1.7	Recommendation 7	Page 7	The recommendation is good, but we urge you to add the role of major public sector employers, such as local government and NHS, as an exemplar of good practice – along the lines of recommendation 9 in	Thank you for your comment. This recommendation has been combined with draft

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				PH42. I believe NICE guidance is still operative in Wales, in which case the guidance should mention the Welsh NHS, as well as NHS England.	recommendation 16 in the final guideline.
Sustrans	1.9	Recommendation 9	Page 9	The bullet referring to physical activity is good.	Thank you for your comment.
Sustrans	1.14	Recommendation 14	Page 12	We suggest you may wish to consider the drafting of this recommendation. The first bullet conflates environmental intervention and promotional / motivational activity. As I am sure you know, many people overlook the importance of the former, so it is important that the physical infrastructure elements should not get lost. We suggest you split this into two parts. It may be risky, also, to list certain of the types of physical intervention recommended, but not all. A casual reader might assume that cycle paths and parks are all that is needed, whereas PH8 gives a much more complete overview of effective environmental interventions, including things like road user charging and traffic calming. These issues might possibly be addressed by combining this recommendation with No 4.	Thank you for your comment. The wording has been revised in the final guideline. Thank you for your comment. The recommendation links to Physical activity and the environment. It would not be appropriate to repeat the content. The Public Health Advisory Committee (PHAC) is of the view that this should remain a separate recommendation.
Sustrans	4.27	Section 4.27	Page 25	The statement is true, but having mentioned several major NCD areas	Thank you for your comment.

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				for which physical activity is protective, it feels a little odd not to complete the list. Also, a formula such as 'many forms of cancer' might be better, as the evidence is not I think secure for all forms of cancer.	The wording has been revised in the final guideline.
Sustrans	4.28	Section 4.28	Page 25	It may be helpful to note here that the funding to cover the cost of much environmental intervention, such as in the field of active travel, would originate with government departments, such as DfT. Under the current administration, much of such funding is presently packaged up within the Local Growth Fund and effectively steered at local level by Local Enterprise Partnerships, rather than by the local authorities themselves.	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider this change necessary.
Sustrans	5.0	Section 5	Pages 27 - 29	We would be interested to know more about the relationship between local air pollution and dementia. This might be an additional research recommendation.	Thank you for your comment. The template restricts the number of research recommendations that can be made.
UK Health Forum	15.0	General		In a joint effort with Public Health England, the UKHF produced the Blackfriars Consensus on promoting brain health and reducing risks for dementia, following a meeting of public health practitioners, policy makers, voluntary and community representatives, and researchers in January 2014. Over 60 leading experts and organisations concerned with dementia and non-communicable disease prevention have signed the consensus statement including the health ministers of the four UK nations. A key recommendation of the statement is for the	Thank you for your comment.

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				development of national policy guidelines to translate the evidence on preventing and reducing the risk of dementia into practice, in order to aid implementation. UKHF therefore warmly welcomes this comprehensive set of draft guidance and recommendations to support the prevention of dementia in mid-life.	
UK Health Forum	15.0	General		While we recognise that the focus of this guideline is on dementia prevention in mid-life, opportunities for dementia prevention begin from pre-conception and early life and continue throughout life into old age. We therefore strongly recommend that once this guideline is complete, NICE should develop a more comprehensive guideline and recommendations on dementia prevention across the life-course.	Thank you for your comment. Consideration 4.5 acknowledges this point.
UK Health Forum	1.0	Population level recommendations, 1-7	4-7	We strongly support the recognition within the guidance of the importance and effectiveness of national population-level recommendations in dementia prevention. We particularly welcome the focus of the recommendations on reducing the affordability, accessibility and accessibility of unhealthy products including tobacco, alcohol and foods high in fat, salt and sugar; as well as the recommendations to develop environments which support more physical activity. We outline some suggestions on how some of these recommendations can be strengthened below.	Thank you for your comment.
UK Health Forum	1.6	Recommendation 6	6	First bullet point “Introduce a national framework for action to help people adopt and maintain a healthy diet.” The marketing recommendation could be strengthened as follows: Extend current TV advertising restrictions on food and drink high in fat, salt or sugar to 9pm, and non-broadcast media (NICE guidance PH25, reducing CVD) Also suggest changing all references to “added sugars” to “free	Thank you for your comment. The wording in the final guideline has been revised To ‘reducing availability and promotion of foods that can contribute to an unhealthy diet. For example, by

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				sugars" in line with recent proposals from the Scientific Advisory Committee on Nutrition.	reducing or limiting the number of food outlets in a given area selling foods high in salt, saturated fat, artificial trans fats and free sugars.' The term 'free sugars' has been used.
UK Health Forum	1.6	Recommendation 6	7	"Activities to make people aware of what constitutes a healthier diet" should including continuing to promote and encourage more food companies to adopt the UK's Front of Pack nutrition labelling scheme with traffic lights (Recommendation 6 in NICE guideline PH25, preventing CVD)	Thank you for your comment. The recommendation links to the Prevention of cardiovascular disease in the final guideline. It would not be appropriate to repeat the content.
UK Health Forum	1.8	Awareness raising recommendations 8-9	7-9	We strongly support the recommendations for awareness raising and education campaigns, aimed at the general public, on the preventability of dementia and how people can age well. Recognition of the need for such messages to avoid stigmatising individuals is welcome, and lessons can be learned from the experiences of other NCDs such as cancer in this regard.	Thank you for your comment.
UK Health Forum	1.9	Recommendation 9	9	Change reference to "sweetened drinks" to "sugar sweetened drinks."	Thank you for your comment. The final guideline refers to beverages.
UK Health Forum	1.10	Service organisation and delivery	10-14	We welcome this comprehensive set of recommendations on service delivery, especially the focus on integrating dementia prevention within existing NCD programmes and incorporating dementia prevention into	Thank you for your comment.

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		recommendations 10-16		routine appointments and contacts in order to maximise resources and opportunities.	
UK Health Forum	1.10	Recommendation 10	10	We support the recommendation to include dementia prevention advice within the NHS Health Check programme. At present the dementia questions are only raised with people aged 65-74, we therefore support the proposals to include these questions in all age-groups included within the health checks, starting at age 40.	Thank you for your comment.
UK Health Forum	1.15	Recommendation 15	13	UKHF recently published the findings of a survey which aimed to assess awareness of dementia prevention within the public health and healthcare workforce. It found that 50% of respondents were not aware, or felt their colleagues weren't aware that dementia is preventable. Therefore, the recommendation on public health training and CPD should: a) Aim to educate the workforce that i) dementia is preventable as well as ii) how it can be prevented b) Include Health Education England as a key organisation with responsibilities for delivery	Thank you for your comment. The Public Health Advisory Committee (PHAC) did not consider that the first suggestion was required. Health Education England has been added to the table in section 2 of the final guideline.
UK Health Forum	1.14	Recommendation 14	12	The reference to walking and cycling should be for all local journeys – as opposed to just cycling to work.	Thank you for your comment. This change has been made in the final guideline.
UK Health Forum	2.0	Who should do what at a glance	15	Add Health Education England to the list to support Recommendations 15 and 16.	Thank you for your comment. Please see response above.
UK Health Forum	5.0	Recommendations for research	27-28	We support this comprehensive list of recommendations for research including on effective and cost-effective interventions for mid-life interventions as well as the prevalence and role of psychosocial risk and protective factors. We also support further research into the effectiveness and cost-effectiveness of the NHS health check	Thank you for your comment.

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				programme.	
UK Health Forum	15.0	General – mental health	29-30	We note that with the exception of NICE guideline 22 on promoting wellbeing at work, there is a gap in terms of NICE guidance on promoting mental health within the population (and preventing mental ill-health such as depression). The Global Burden of Disease study ranked depression as the 3rd cause of years of life lived with disability in the UK. It is also an important risk factor for dementia. We strongly recommend that NICE address this gap as a matter of urgency given the high burden of poor mental health, and its association with physical health. A number of wider social and environmental factors such as employment, housing and crime are linked with poor mental health – and those responsible for these services should therefore be involved in health promotion and prevention efforts.	Thank you for your comment. NICE produces guidelines on topics referred by the Department of Health.
UK National Screening Committee	**1.10**	**Recommendation 10** Develop the NHS Health Checks programme to promote opportunities in mid-life to reduce the risk of dementia, disability and frailty. Tailor the advice component of the NHS Health	10	The devil is in the detail here. I trust that this recommendation will not imply or lead to new tests for attendees at the health check. This would be a screening recommendation and as should be properly assessed by the UKNSC as outlined in a MOU with NICE. We have I fact recently updated our advice on screening for dementia and found that the best tests (those for cognitive function) do not perform well enough to be used in a national screening programme.	Thank you for your comment. The recommendation does not suggest screening for dementia - it is about raising awareness about risk reduction.

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		Check programme for different age groups. Add dementia prevention advice to all health checks.			
The UK-CAB – the network of HIV treatment advocates	1.1	Draft Recommendation 1	Page 4	Re: 'Make smoking tobacco and drinking alcohol less accessible, affordable and acceptable.' Your Glossary says, 'Affordability measures include the use of taxation, pricing and subsidies to deter purchase of unhealthy commodities such as foods that have a high saturated fat and/or sugar content, cigarettes and alcohol [. . .] Comment: 1. There should be a financial penalty, too, on food and tobacco companies, and producers of alcohol, especially where they sell foods, tobacco products and drink products, all for profit, which could be a danger to the long-term health of the population. The tax and penalty burden should be shared by the food and drink industry. 2. Affordable should be properly defined. In the Housing Association sector, for example, it has come to mean 80% of	Thank you for your comment. The recommendations reflect the available evidence. Thank you for bringing this example to our attention. It suggests that each commodity would require a separate definition, and no evidence was identified to enable this.

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		Draft Recommendation 2	Page 4	the typical private-sector rent in the locality. In making it 'clear that some common behaviours can increase the risk of disability, dementia and frailty in later life', the Group (NICE Public Health Advisory Committee D) should also warn the food, drinks and tobacco companies that they are encouraging these risk behaviours in the population.	Thank you for your comment. The audience for the awareness raising campaign is for the whole population.
The UK-CAB – the network of HIV treatment advocates	1.3	Draft Recommendation 3	Page 5	Public Health England, NHS England and trading standards officers should consider the ethics of producing tobacco products that are addictive. (This should also apply to foods with high added-sugar content.)	Thank you for your comment. This is beyond the remit of NICE.
The UK-CAB – the network of HIV treatment advocates	1.5	Draft Recommendation 5	Page 6	'Restricting the availability and marketing of alcohol,' may be a good idea. Producers should be also be legally obliged to produce 'good tasting' low-alcohol products. This should be part of consumer choice.	Thank you for your comment. The recommendations reflect the available evidence.
The UK-CAB – the network of HIV treatment advocates	1.6	Draft Recommendation	Page 6	Draft Recommendation 3 states that taxation should be used to increase the price of tobacco. Does 'Financial and regulatory	Thank you for your comment. This part of the

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		6 6 (cont)	6 (cont)	measures to reduce the level of salt, saturated fats, artificial trans fats and added sugars [. . .], mean a taxation on these foods? 1. Does the burden of taxation – in 3 and also here in 6 – fall exclusively on the shoulders of the consumer? 2. Shouldn't the producers also pay an increased direct tax contribution on their produce? Can this be ring-fenced so that it is not passed on to the consumer? Measures to reduce the availability of foods that can contribute to an unhealthy diet include reducing or limiting the number of fast food outlets and placing controls on the sale of 'street foods'. The Group doesn't define fast food or 'street food' in the Glossary. Is there a difference between fast food that has added sugar, for example, and fast food that is quick and convenient and has no additives? Are additives intended to improve the flavour? But do they also promote addiction in some instances?	recommendation has been removed from the final guideline. Thank you for your comment. These terms are no longer used in the final guideline.
The UK-CAB – the network of HIV treatment advocates	1.8	Draft Recommendation 8	Page 7	National government, Public Health England and NHS England should also use national media campaigns to emphasise that growing old is a natural condition of life. Campaigns around 'the ageing population' fail to inform the general population that everyone (hopefully) becomes part of the ageing population in the end.	Thank you for your comment.
The UK-CAB – the network of HIV treatment advocates	1.8	8 (cont)	8 (cont)	Reaching high-risk communities in campaigns must also address any psychosocial pressures (including poverty, homelessness and	Thank you for your comment. These types of issues are

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				deprivation; and stigma and discrimination – such as in HIV) that might drive communities into such behaviours.	acknowledged in consideration section in the final guideline.
The UK-CAB – the network of HIV treatment advocates	1.9	Draft Recommendation 9	Page 9	Informing the population about the harmful effects of consuming alcohol and/or foods that are high in salt energy-dense processed snacks and sweetened drinks could show benefits to health. The same information must be read and understood by the producers of these products, they should be required to justify why they are putting these products on sale.	Thank you for your comment. The audience for the awareness raising campaign is for the whole population.
The UK-CAB – the network of HIV treatment advocates	1.12	Draft Recommendation 12	Page 11	What is the evidence to recommend providing 'multicomponent online interventions (web and app-based) to help people change behaviours? Are different online interventions more successful than others? The interventions should be made specific to the health risk behaviour that they seek to change.	Thank you for your comment. Please see section10 of the guideline which links the recommendations to the evidence in the commissioned reviews. The evidence reviews are available on the NICE website (Please see Supporting documents).
The UK-CAB – the network of HIV treatment advocates	1.15	Draft Recommendation 15 15 (cont)	Page 13 13 (cont)	Local authority commissioners, clinical commissioning groups and third sector organisations who receive funding, should not rely on the unpaid expertise of community volunteers to bring about change in risk behaviours for long-term health. Payment by results might be a fairer	Thank you for your comment. The recommendations do not suggest reliance on community volunteers. However they do

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				approach.	acknowledge the important contribution the voluntary sector makes.
The UK-CAB – the network of HIV treatment advocates	2	2 Who should take action? Introduction	Page 15	The 'Who should do what at a glance' is very comprehensive. But care should be taken with measures around 'affordability'. The action for recommendation (4) for Providers of social housing must clarify the term 'affordable rents', especially where affordable means 80% of the private-sector rent.	Thank you for your comment. Please see previous response.
The UK-CAB – the network of HIV treatment advocates	4	4 Considerations General The Evidence Research	Pages 19 – 29	The adverse effects on mental health of long-term conditions, such as Type 1 diabetes or HIV, has long been discussed. The Group should take this into consideration when making these recommendations for later life. Basic needs around housing and employment should be addressed (4.9), but there are added pressures for some populations: people living with HIV in the UK today still suffer stigma and discrimination. The Group should also recommend campaigns to eradicate 'popular' targeting in society of vulnerable groups such as the young disabled or people living with HIV. Evidence should be able to show who benefits most from the intervention of online interventions (web or app-based). Is there evidence that an app to help encourage more walking is more effective than an app to help smoking cessation?	Thank you for your comment. The PHAC did consider the impact of long-term conditions on both physical and mental health. Thank you for your comment. This section gives examples of the issues discussed by the Public Health Advisory Committee (PHAC) when making recommendations. It cannot cover every issue. Please see previous response to this point.

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				It is important that the Group has made a recommendation for research into psychosocial risk factors throughout life such as loneliness, isolation and depression. The HIV community would ask for research into these psychosocial pressures in relation to living with HIV. Can this – along with the stigma of HIV – also have an effect on disability, dementia and frailty in later life, regardless of HIV-associated conditions?	Thank you for your comment. The focus of the guideline is on prevention of dementia, disability and frailty. It does not cover the impact of living with a condition.