National Institute for Health and Care Excellence

Physical Health of people in Prisons
Scope Consultation Table
07/10/14-04/11/14

ID	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
72	SH	British Dental Association	1	**General**	The British Dental Association supports the development of NICE guidance in this area. In England however, NHS England are planning to commission further contracts for prison dentistry with an estimated start date of April 2016. If this timescale is met, this NICE guidance will not be in place to support that process.	Thank you for your comment. Unfortunately this is beyond our control at this stage.
73	SH	British Dental Association	2	**Section 2 Remit Section 3.1(d) Section 4 Section 4.2 (a)**	The remit suggests that this scope is solely for NHS England commissioned services yet the website states that this is guidance for England, Wales and Northern Ireland. Much of the scope refers to the system in place in England which does not reflect the system in place in Wales and Northern Ireland. Clarification on how this relates to Wales and Northern Ireland would be helpful.	Thank you for your comment. NICE provides guidance for England. Decisions on how NICE guidance applies in Wales and Northern Ireland are made by the devolved administrations.
74	SH	British Dental Associati	3	**General**	Within a recommendation, each action point should be specifically attributed to the relevant subset of the audience for whom the whole recommendation is intended. There have previously been cases where dentists were listed	Thank you for your comment. The final recommendations

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		on			among a group of healthcare professionals who were the target audience of a recommendation, but not all of the individual action points within the recommendation were appropriate/intended for dentists. Since dentists in England are contractually obliged to follow NICE guidelines, such ambiguities should be clarified within the guidance and not left open to interpretation.	will be extensively checked for clarity and specificity as part of the NICE guideline development process.
75	SH	British Dental Association	4	**Section 3.2 (b)**	Training – While we support NICE guidance on addressing the physical health of people in prison we would urge that this is part of a wider programme of training for those working in the prison environment (which includes induction for new dental professionals).	Thank you for your comment. We recognise the importance of this topic, however this is not a priority for this guideline.
76	SH	British Dental Association	5	**Section 4.3.1** Promoting health and wellbeing in prison	Oral health is mentioned in relation to education but we would like to expand this to highlight the role of promoting good oral healthcare in self-care.	Thank you for your comment. The guideline will consider approaches to promote health including oral health.
77	SH	British Dental Association	6	**Section 4.3.1** Early health needs assessment	We recommend that oral healthcare form part of that initial assessment because early assessment of oral health status and treatment need would assist with treatment of urgent conditions and general care. Including oral healthcare as part of early needs assessment would ensure that those prisoners using medication (e.g. methadone) which can cause detrimental side effects on oral health can be swiftly identified and their	Thank you for your comment. The GDG will consider which elements to include within assessments after examining the available evidence.

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					treatment planned accordingly. To highlight the importance of oral healthcare at early assessment stage, in 2007 the WHO noted that "prisoners with substance misuse problems are likely to report toothache very soon after entering prison, as any opiate drugs they took suppressed toothache".	
78	SH	British Dental Association	7	**Section 4.3.1** Coordination and communication between healthcare professionals	We recommend that dentists and their teams are fully integrated into the prison health team to ensure open channels of communication. There are many opportunities for multi-professional working in the prison environment which would be of real benefit to the patient for example management of chronic conditions such as diabetes. The dental team could have a key role in assisting with smoking cessation programmes.	The GDG will be looking at methods of coordination and communication between all healthcare professionals.
79	SH	British Dental Association	8	Section 4.3.1 Use of medication	The BDA is very aware of the need for antimicrobial resistance stewardship and we would ask that this guidance be developed in tandem with the NICE guidance being developed on AMR.	Thank you for mentioning this guidance The antimicrobial stewardship guidance (currently under development) has been added to the 'Related guidance' section of the scope.
80	SH	British	9	**Section**	We support the development of guidance for those entering prison and for	Thank you for your

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		Dental Association		**4.3.1** Continuity of healthcare on admission to prison, transfer, or on release to the community	the transfer of records when a patient transfers to a new prison. Continuity of oral healthcare for patients in prison is very important particularly because of the high-needs elements of these patients. The transfer of patient records when a patient moves from one facility to another is something the BDA has long advocated to ensure continuity of care. In England and Wales, dental records do not transfer to the prison primary healthcare service on entry to prison because in primary dental care there is no centralised (or standardised electronic) patient record and patients are not 'registered' with a dentist. In Northern Ireland prisoner dental records are integrated with the computerised medical record so they are easily transferred between the three prison sites.	comment. We agree that continuity of care is a key clinical issue, as highlighted in the scope.
81	SH	British Dental Association	10	**Section 5.1** Related and published NICE guidance	There is existing published NICE guidance for oral health yet these are not listed. It would useful for there to be awareness of the relevant oral health NICE guidance when developing this guidance.	The guideline will cross refer to existing NICE guidance on oral health where appropriate.
25	SH	College of Occupational Therapists	1	p.6 Promoting health and wellbeing in prison	The College supports the need for teaching self-management. It would also recommend the inclusion of reablement services for prisoners with long term conditions. Reablement-aims to help people accommodate their illness or condition by learning or relearning the skills necessary for daily living (Care Services Efficiency Delivery Programme, Homecare Reablement Workstream 2007). Recipients would benefit from learning to set and meet realistic goals to manage their health and the symptoms of their condition.	Thank you for your comment. The GDG will consider the need for teaching self-management when prioritising review questions and

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					There is evidence in the community that reablement is cost effective. • Care Services Efficiency Delivery Programme, Homecare Re-ablement Workstream (2007) Homecare reablement. Retrospective longitudinal study November 2007. London: Care Services Efficiency Delivery. Available at: http://webarchive.nationalarchives.gov.uk/20120907090129/http://www.csed.dh.gov.uk/_library/Resources/CSED/CSEDProduct/Longit_Study_Final_Version__NEW_FORMAT_.pdf • Francis J, Fisher M, Rutter D (2011) Reablement: a cost-effective route to better outcomes,Research Briefing 36. London: SCIE. Available at: http://www.scie.org.uk/publications/briefings/briefing36/	will perform a full literature search should this area be included. In addition we are aware of NICE guidance in development: Regaining independence (reablement).
82	SH	Department of Health	1	General	Thank you for the opportunity to comment on the draft scope for the above clinical guideline. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation. However, a colleague has forwarded the following observations, of which you may wish to be aware: ***"It used to be common practice that prisoners are allowed 60 minutes a day to go to the exercise yard for some physical activity. We should strongly encourage that practice to continue. I also wonder if NHS Health Checks happen in prisons? Could that or similar health assessment be useful in assessing prisoners health and chronic conditions if they have any"?***	Thank you for your comment. The scope of this guideline does cover health-promoting activities including exercise. In addition health assessments are also covered within the scope and review questions will be prioritised in this area.
5	SH	Dietitians in Obesity	1	General	We welcome this guidance.	Thank you for your comment.

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		Management UK (domUK), a specialist group of the British Dietetic Association				
6	SH	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	2	3.2 Current Practice b)	We agree that health care provided in prisons varies significantly between prisons. This also includes the provision of food. Whilst it is acknowledged that food provision increased in quality, range and choice of meals between 1997- 2005 (Serving Time: Prisoner Diet and Exercise, National Audit Office, 2006), there were concerns at this time that prisoners were provided with meals that relied heavily on convenience foods and there was little use of seasonal produce. As a result, for example, average levels of salt were above government's recommended levels (up to 93% more in the case of the adult male standard meals). The National Audit office (2006) recommended that 'prison caterers should improve the diet of prisoners, especially aspects of diet which could adversely affect health' and that 'The Prison Service should raise the level of awareness of healthy eating among the prison population '.A further audit to assess current practice and whether these recommendations have been addressed is recommended. Additionally an examination of the variations in food provision related to healthcare between the different types of prisons (for example between a	Thank you for your comment. We acknowledge the need for health promotion in prisons, including diet and as such have specified this in the scope as an area for review.

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					young offenders institution or women's prison) is warranted to determine if the different requirements of prisoners according to age and gender are now being catered for (as recommended by the National Audit office, 2006). It could also determine if there are differences in privately run prisons. As food provision and the priority given to it is largely determined by each prison governor, there may be wide variations but good practice could be identified and highlighted as examples to replicate. The standards for the provision of healthy food (at least one meal option labelled as healthy is offered at lunch and in the evening), is below that expected outside the prison service, and as such means that the healthcare opportunities for prisoners are not equal with those outside of prison. The provision of healthy food should be the norm, not the exception.	
7	SH	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	3	4.1.1 and 4.1.2	Although we accept that this guidance relates to adults only, consideration of the health issues of pregnant women and new mothers in prison also has the potential to affect health, wellbeing and long term prospects of their babies. It is well recognised that physical and mental health of expectant mothers, and early life after birth, can permanently affect organ development and function of children. This is also important considering that children of mothers in prison may be more likely to offend in the future; improving health and wellbeing of expectant mothers will have the additional benefit of improving life chances of their children.	Thank you for your comment. This topic is outside of the scope of this guideline.
8	SH	Dietitians in	4	4.3.1 Promotin	Improved opportunities and access to exercise facilities will benefit both physical and mental health and wellbeing of prisoners.	Thank you for your comment. We agree

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		Obesity Management UK (domUK), a specialist group of the British Dietetic Association		g health and wellbeing in prison		that health promotion in prisons, including exercise, is a key area for review.
9	SH	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	5	4.3.1 Promoting health and wellbeing in prisons	Due to the 'chaotic lives' of some short-term prisoners, a period of imprisonment can be the first time they have the opportunity to consider their health needs or access support and services. There is the potential that prisoners can be supported in adopting healthy behaviours, for example in food choices, that can be taken back into the community. By improving the health of individuals confined in prisons, this can also positively affect the health of prisoners' immediate family and relatives.	Thank you for your comment. We agree that health promotion in prisons, including diet, is a key area for review.
10	SH	Dietitians in Obesity	6	4.3.1 Promoting health	The underlying view of a 'health promoting prison' is that health is everyone's business, not just those in traditional healthcare roles. As a result there is a need for a range of staff to be involved (PSO 3200). This requires	Thank you for your comment. We agree that a range of staff

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		Management UK (domUK), a specialist group of the British Dietetic Association		and wellbeing in prisons (and 4.1.1 Groups that will be covered)	the need for policies to support the healthcare of staff working in prisons, so that their physical health also feels valued and they are in a position to be supportive in promoting health and wellbeing in prisons.	may be involved in health promotion activities. However, the care of staff working in prisons is outside of the remit of this guideline.
11	SH	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	7	4.3.1 Coordination and communication between healthcare professionals	We strongly agree that there is often poor coordination and communication between different healthcare teams both inside and outside prisons. In addition to integration of care, it is important that prisoners at the end of their prison terms, have their healthcare needs addressed after release.	Thank you for your comment. The guideline will consider the continuity of healthcare on release from prison.
12	SH	Dietitians in Obesity Manage	8	4.3.1 Urgent and emergen	Conditions such as cancer, stroke and coronary artery disease are recognised to be multifactorial in origin. A multitude of lifestyle factors such as smoking, physical activity, sedentary behaviours, poor diet and stress are risk factors, and many of these may cluster in this vulnerable population	Thank you for your comment. The scope of this guideline includes promotion

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		ment UK (domUK), a specialist group of the British Dietetic Association		cy management in prison	group. Managing poor lifestyle choices and encouraging healthful behaviours are likely to positively impact upon risk of these conditions in this population group.	of health and wellbeing in prison, which will link to this section of the guideline where relevant.
13	SH	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	9	4.5 Review questions	We agree that health assessment should be undertaken at reception to determine health needs, and would encourage this to include weight, height, body mass index and waist circumference as indicators of body weight and fat distribution (and therefore risk). However we would encourage regular monitoring of these measurements throughout prison terms since excess weight is a well recognised risk factor for several chronic diseases.	Thank you for your comment. The guideline will consider the evidence for subsequent health assessments as well as for assessment on reception.
93	SH	Health and Justice Clinical Referenc	1	General	Children and Young People (CYP) - whilst the group understands the document scope does not include CYP we wish to raise that CYP experience considerable physical (and mental health) needs. We would welcome NICE considering an extension of its guidelines to meet the needs of CYP and specifically the transition of CYP to the adult estate.	Thank you for your comment. Children and young people under the age of 18 are outside of the

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		e Group				scope of this guideline. However young people transferring from young offender institutions to adult prisons are included.
94	SH	Health and Justice Clinical Reference Group	2	General	Immigration and removal Centres (IRC)- the group are surprised to learn that IRC estate has been included in the scope of the mental health work but not the physical health program. We would advocate NICE revisiting this decision as the population in the IRCs bear a remarkable similarity to those in the general prison population. Managing their physical health needs is an important element of their detention and alongside improving outcomes for them as individuals could potentially make a contribution to the public's health. We are confident that in the main the range of disorders and conditions in IRCs will be the same as the prison population with only the concentration in the IRC for certain health issues being greater. It is therefore the Health & Justice CRGs view that IRC health should be included in the scope.	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
83	SH	Heart of Mersey	1	4.1.1	The scope document suggests that special consideration should be given to women, especially pregnant women and the mothers of babies' in prison. Whilst it is understandable that special consideration needs to be given to pregnant women and mothers of babies, HoM are not of the opinion that special consideration should be given to all women, solely based on gender. True, the needs of men and women are somewhat different, but special consideration alludes to enhanced care which in this case would not be	Thank you for your comment. The intention of listing women as a group for 'special consideration' is to explore gender

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					considered fair under equality of opportunities.	differences, and not to prioritise treatment of women.
84	SH	Heart of Mersey	2	4.1.1	HoM are aware that there are often health disparities between the quality of health and healthcare across racial and ethnic groups. Some disease are more prevalent in certain ethnic groups- for example, cardiovascular related illnesses are more prevalent in men from the indian subcontinent. It is clear that each population group, either that determined by religion or ethnicity, has differences in terms of illness behaviour seeking assistance with health matters and beliefs about illness. Therefore HoM suggests it may be advisable to consider race and ethnicity amongst the prison population	We agree and will consider equality issues when reviewing the evidence and making recommendations. NICE is committed to ensuring that its guideline development process fully meets duties under the Equality Act (2010).
85	SH	Heart of Mersey	3	4.1.1	An NHS study conducted in 2007 estimated that 12,000 gay men die from smoking related diseases every year. LGBT people who according to a UCL study are up to twice as likely to have smoked than their heterosexual peers. HoM are of the opinion that statistics such as this, especially around minority groups, and not solely around gay men and smoking should be taken into consideration.	We agree and will consider equality issues when reviewing the evidence and making recommendations. NICE is committed to ensuring that its guideline development process fully meets

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						duties under the Equality Act (2010).
86	SH	Heart of Mersey	4	4.1.1	The scope states that special consideration should be given to people over 55. In the community anyone over the age of 40 is invited for a health check, HoM propose that this should also be the case within prisons to ensure consistency of care.	NHS health checks will be considered as part of the health needs assessment section of this scope. We are aware that these are recommended for people over 40 years; other assessment tools or screening programmes are recommended for different age groups. This is a separate issue from the age at which prisoners should be considered 'older' prisoners, for whom we will be looking for distinct evidence.
87	SH	Heart of Mersey	5	4.3.1	Promoting health and Wellbeing in Prison HoM agrees with the rationale here and believes that prison should be an opportunity for everyone regardless of literacy, gender, race etc to have the opportunity to improve their health, and to be able to continue with learnt	Thank you for your comment.

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					health behaviours on release from prison.	
88	SH	Heart of Mersey	6	4.3.1	Promoting health and wellbeing in Prisons The scope suggests that health-promoting activities in prisons may cover "diet, weight management and food available in prison" which is welcomed. However HoM believe that there should be a focus on cooking skills and budgeting in order for prisoners to maintain healthy lifestyle once released from prison.	Thank you for your comment. The health promoting activities listed in the scope are given as examples. The Guideline Development Group will determine the areas to be reviewed.
89	SH	Heart of Mersey	7	4.3.1	Promoting Health and Wellbeing in Prison Health promoting activities to cover smoking and smoke free prisons are welcomed however HoM believe that NRT should be available to support these in prison to give up smoking.	Thank you for your comment. The health promoting activities listed in the scope are given as examples. The Guideline Development Group will determine the areas to be reviewed.
90	SH	Heart of Mersey	8	4.3.1	Use of Medication HoM agrees with the rationale around the use of medication, but would like to suggest an element of education around medication, why it has been prescribed, effects of the patients health etc. To include education and warnings to prevent trading prescriptions drugs amongst fellow prisoners.	Thank you for your comment. The guideline will also cross refer to existing NICE guidance on

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						medicines adherence (CG76), which makes recommendations on patient involvement in decisions about medicines, including communication, understanding the patient's knowledge, beliefs and concerns about medicines and providing information.
91	SH	Heart of Mersey	9	4.3.1	Continuity of healthcare or admission to prison, transfer or on release to the community As stated in the rational, continuity of treatment and recovery support if central to good treatment outcomes and avoiding resources being wasted. HoM therefore believe it is essential that serious thought is taken around the transfer of GP medical records to the prison, as reliance of state of health from the prisoner alone may result in either incorrect or missed diagnosis of health conditions.	Thank you for your comment. The management of medical records will be considered as part of this guideline.
92	SH	Heart of Mersey	10	4.3.1	Continuity of healthcare on admission to prison, transfer or on release to the community In addition to the above, to ensure continuity of care HoM feel it is important to have the ability, knowledge and necessary information to be able to signpost to services for heath and healthcare services.	Thank you for your comment.
34	SH	Leeds Communi	1	General	I am chair of the Professional Advisory Panel to the Police Custody Healthcare Service for West and South Yorkshire Police Custody which is	Thank you for your comment. This

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		ty Healthcare			responsible for advising on the transfer of commissioning responsibility from the police to NHS in this area. The multi professional advisory panel is made up of expert leaders in the field of custodial/police health services from both a commissioning and provider perspective. The panel is concerned regarding the significant mismatch between the recently consulted *Mental Health of People in prison* which has a more comprehensive scope and describes a pathway in to and out of the prison setting for mental health and substance misuse problems, whereas the physical health in prison scope does not take this comprehensive approach. All people who go in to prison pass through police custody and it is a critical point of the pathway in terms of identifying health need and treating urgent conditions in a physically vulnerable population. Assessment, management and treatment of physical health needs at the police stage has a direct impact on assessment, management and treatment in prison custody. The panel would strongly advise that NICE consider including the physical health needs of those in police custody as part of the prison health scope so that a) critically it is in line with the mental health approach of NICE's other current work but also b) enables much needed guidance and advice on health and its management in police custody to be developed. The earlier in the offender journey (i.e. police contact) that health needs are identified will mean; significantly improved clinical outcomes, clinically safer custodial health services and a reduced costs to prison health services further down the pathway.	population is outside of the scope of this guideline as the remit from NHS England is to produce guidance for 'people in prison'. This is different from the remit of the guideline relating to mental health, which has been commissioned to cover the whole criminal justice system pathway.
26	SH	Medact	1	General	The population of I R Cs and prisons have some problems in common, but there are differences. The first one being that if an I R C doctor thinks that a detainee is mentally or physically ill, or has been tortured in their own country, he should fill in a rule 35 form with the intention of returning the detainee to the community. I R C doctors have told me that they find filling the rule 35 forms very difficult, they do not have the time to complete a proper examination with history and assessment of torture scars according	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons.

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					to the Istanbul Protocol and they fear that they may have to attend court to justify their report. This is not of course the case in prisons, where the prison doctor needs to manage the sick patient within the prison unless they need to be hospitalised, and there is no rule 35.	Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
27	SH	Medact	2	General	So my first suggestion is that IRC doctors are given enough time to complete these forms, and also training on recognising the mental and physical scars of torture. This is very important, because victims of torture frequently suffer from Post Traumatic Stress Disorder, which is exacerbated by incarceration in an I R C.	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
28	SH	Medact	3	General	Important to both prisons and IRCs is the continuation of care if the prisoner/detainee is already under the care of their GP, Community Mental health Care Team (CMHCT), secondary or other care prior to detention. I have seen many cases where operations and out patient appointments have been cancelled because an asylum seeker has been detained. And we should remember that the asylum seeker has not transgressed our laws.	Thank you for your comment. Stakeholders have advised that there are important differences between

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					Detention for them is administrative, indefinite, and arbitrary. So a careful history should be taken on admission and every effort made to continue health care, including obtaining the GP's notes (which will contain any letters from hospitals etc:). Then on release the detainee/prisoner should have a summary of their care in the IRC/prison to present to their GP. I have seen too many notes 'lost' when lawyers have asked for them after the detainee has been released.	IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included inthe scope of this guideline.
29	SH	Medact	4	General	I agree with the sentiment that admission to prison can be a good moment to give health advice and screening. We have had some cases of TB in the I R Cs recently, which have been missed, and in my opinion TB screening and maybe also HIV screening, with the appropriate counselling, should be added to the guidelines.	Health assessments on admission to prison will be considered by this guideline.
30	SH	Medact	5	General	As for disabilities I cannot see why a person in a wheel chair should be detained in an I R C, they are most unlikely to abscond. In 'Breakthrough Britain' (Asylum Matters Report from the Asylum and Destitution Working Group 2008) page 68 "At most only 8-9% of asylum seekers who get bail subsequently attempted to evade the asylum system". We should encourage doctors to query the detention of the disabled.	Thank you for your comment.
31	SH	Medact	6	General	Many of my patients have complained to me that when they were taken to outside healthcare as an in or out patient that they have been made to wear handcuffs, even though their only sin is to seek asylum. It would be good to add to the NICE guidelines the words from the BMA 'Medical role in restraint and control: Custodial settings (Aug 2009): This guidance applies primarily to people detained in prisons but may also be relevant to prisoners in police stations, young offenders' institutions and asylum seeker detention centres. Doctors have a duty to provide for each of	Thank you for your comment. Levels of security required for the movement of prisoners are determined by NOMS and are outside the remit of this guideline.

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					their patients the best possible care in the particular circumstances. This includes respect for the patients' dignity and privacy. These issues are equally as important when treating those detained in prison, whether convicted or on remand, as when treating any other patient. It is important that doctors try and ensure that prisoners have access to the same standards of health care as are available to the rest of society. When prisoners are taken outside the prison grounds for medical care, the duty of the health care team to provide optimal care can conflict with the prison authorities' duty to ensure that appropriate levels of security are maintained. It is therefore necessary to reach a balance between the dignity of the patient and security needs. Where there is a serious risk of escape or the prisoner represents a threat to him or herself, the health team or others, safeguards are required. These safeguards, however, should be commensurate with the actual or perceived risk and should respect the patient's right to privacy to the maximum extent possible.	
32	SH	Medact	7	General	In my opinion there should be a comprehensive training for the medical staff in the I R Cs as the care of asylum seekers is very complex, not only the possibility that they have been tortured, but the fact that they may have tropical diseases; may have been living rough and have a high incidence of TB; need immunisation and malaria cover if they are returning to a country where tropical diseases are endemic; and have considerable mental health problems because they find that the indefinite detention is very distressing.	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs

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						have not been included in the scope of this guideline
33	SH	Medact	8	General	The training could be either by the RCGP's Secure Environment Group, which I hear is thinking of a training package with 10 hours on the computer and a day workshop, I R C medicine being part of that training. Or by MEDACT's Torture and Human Rights section as a day training for I R C doctors, which is also being planned.	Thank you for your comment.
34	SH	Medact	9	3.1	Persons in administrative and discretionary immigration detention (IDs) should be included as a specific category, as they often have unusual epidemiologies - medical histories, clinical needs and cultural and linguistic characteristics	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline
35	SH	Medact	10	4.1.2	I note first that the mental health 'scope' addresses the problems of mental health care in prisons and in I R Cs, and the physical health 'scope' does not include the I R Cs. However, there are many physically ill patients in I R Cs, and many of those have complained that they are not happy with their medical care, which is why I, and many other volunteer doctors, have visited them.	Thank you for your comment. Stakeholders have advised that there are important differences between

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						IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
36	SH	Medact	11	4.1.2	The exclusion of IDs is inappropriate, and has (I understand) been revoked. IDs do come within the remit of NHS England.	Thank you for your comment. Stakeholders have advised that there are important differences between immigration detainees (IDs) and prisoners. Since IDs are not prisoners they are outside the remit for this guideline. For these reasons IDs have not been included in the scope of this guideline
37	SH	Medact	12	4.2	See 4.1.2	Thank you for your comment. Stakeholders have

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						advised that there are important differences between IDs and prisoners. Since IDs are not prisoners they are outside the remit for this guideline. For these reasons IDs have not been included in the scope of this guideline
38	SH	Medact	13	4.3.1	Key management issues for IDs should include recognition of tropical diseases, evidence of torture or other reason for unfitness for detention (as defined by law) and appropriate communication of such evidence.	Thank you for your comment. Stakeholders have advised that there are important differences between IDs and prisoners. Since IDs are not prisoners they are outside the remit for this guideline. For these reasons IDs have not been included in the scope of this guideline.
39	SH	Medact	14		IDs pose specific issues with regard to repeated and unpredicted transfer between centre, to secondary care, or release or removal from the UK, and	Thank you for your comment.

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					preparations for these eventualities.	Stakeholders have advised that there are important differences between IDs and prisoners. Since IDs are not prisoners they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
40	SH	Medact	15	4.4	(For IDs) – appropriate release, use of medical hold, preparation for removal.	Thank you for your comment. Stakeholders have advised that there are important differences between IDs and prisoners. Since IDs are not prisoners they are outside the remit for this guideline. For these reasons IDs have not been included in the scope of this guideline.
41	SH	Medact	16	4.5	Review questions – are methods of audit in current use fit for purpose?	Thank you for your

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						comment. Audit has not been prioritised as an area for review in this guideline.
42	SH	Medact	17	4.6	Economic aspects (for IDs) should include costs of detention found to be unlawful by the courts, including compensation, legal costs and costs of wrongful detention which should have been addressed through procedures laid out in statute and secondary legislation.	Thank you for your comment. IDs have not been included in the scope.
14	SH	Medical Justice	1	General	Medical Justice welcomes these guidelines on physical health in prisons but are concerned that they do not encompass detainees held in Immigration Removal Centres (IRCs).	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
15	SH	Medical Justice	2	General	As the only organisation to send independent doctors in to visit detainees held in IRCs we have great concerns about provisions for healthcare in these facilities.	Thank you for your comment. Stakeholders have advised that there are important differences between

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						IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
16	SH	Medical Justice	3	General	We recommend that separate guidelines are drafted to address the specific needs of those held in IRCs. In the absence of such separate guidelines we recommend that the remit of these guidelines be broadened to include those held in IRCs, as have the guidelines on "mental health of people in prison" currently being drafted. Should this not be possible we ask that the needs of those held in prisons solely under immigration powers be explicitly addressed in these guidelines.	Thank you for your comment. We agree that due to the specific needs of IRCs, these should not be included within this scope.
17	SH	Medical Justice	4	General	Immigration detainees risk being a forgotten group with great health needs	Thank you for your comment. We agree that this group has specific needs.
18	SH	Medical Justice	5	General	They are not criminals and including them in a document when all others are within the criminal justice system risks 'criminalisation' by association – we believe there should be separate and additional guidance for immigration detainees in prisons, as well as for immigration detainees in immigration removal centres.	Thank you for your comment. We agree that due to the specific needs of IRCs, these should not be included within this scope.
19	SH	Medical Justice	6	General	There are some crucial differences about immigration detention, in that it is supposed to be optional and used for those with significant mental or	Thank you for your comment. We agree

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					physical illness only in very exceptional circumstances. Release from detention is the most cost-effective and preferred clinical choice. This option is not available to prisoners in the same way.	that due to the specific needs of IRCs, these should not be included within this scope.
20	SH	Medical Justice	7	General	There are serious complications for treatment from the potentially very short lengths of stay in a prison for many immigration detainees, the indefinite nature of detention, the problems with follow-up after discharge, even if the in-house healthcare aspects can be adequately resourced, which they are not at present.	Thank you for your comment. We agree that due to the specific needs of IRCs, these should not be included within this scope.
21	SH	Medical Justice	8	General	Some special issues not usually seen in the criminal justice system are found, including sequelae of torture, but giving this the emphasis needed in a general document may be difficult – we believe there should be separate / additional guidance for immigration detainees in prisons, and in immigration removal centres.	Thank you for your comment. We agree that due to the specific needs of IRCs, these should not be included within this scope.
22	SH	Medical Justice	9	General	If there is no prospect for separate / additional guidance for immigration detainees in prisons and in immigration removal centres then we want to advise on the detention aspects of the joint guidelines.	thank you for your comment. IRCs are not being included within the scope. Stakeholders will be invited to comment on the guideline during the public consultation.
23	SH	Medical	10	General	Medical Justice has registered as an independent stakeholder and has not	Thank you for your

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		Justice			authorised any other organisation or individual to speak on our behalf.	comment
95	SH	National Offender Management Service	1	General	We are pleased that NICE have agreed to look at this area and very much welcome the development of the guidelines. We have discussed with the Mental Health in Prisons Guidelines team that we would be delighted to act as **Expert Witnesses** and **Peer Reviewers** and would be more than happy to undertake a similar role for the Physical Health guideline if helpful? We are also happy to arrange and facilitate access to establishments to support the guideline development.	Thank you for your comment. We are currently recruiting for a NOMS member to take a role as a co-opted expert.
96	SH	National Offender Management Service	2	General	Scope – we would welcome clarification as to proposed treatment of prisons in Wales in the Guideline recognising that while it is part of the same Justice system healthcare responsibilities are different (ie not NHS England)	Thank you for your comment. NICE provides guidance for England. Decisions on how NICE guidance applies in Wales is made by the Welsh Assembly.
97	SH	National Offender Management Service	3	P1 Bullet C	In setting out the context the information in this section is rather dated eg it lists 140 prisons in England and Wales as of 2011. We would be happy to support updating this information	Thank you for your comment. We will be exploring more up to date information for the guideline.
98	SH	National Offender Management Service	4	P4 – 4.4.1	Is there a risk of duplication with the MH in prisons guideline group as their scope mentions also considering Learning Difficulties & SMS?	Thank you for your comment. We are in contact with the Mental Health in Prisons guideline developers and will

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						ensure the guidelines dovetail.
99	SH	National Offender Management Service	5	P4	Older prisoners are defined in the draft as being over 55. Current NOMS practice tends to look at prisoners over 50 years of age as being older and NHS Health checks for are being offered to those aged 45 and over? It would be useful to agree a standard definition	Thank you for your comment. This age has been changed to 50 to reflect current NOMS practice.
100	SH	National Offender Management Service	6	P5	IRCS are listed as being out of scope for this review but in scope for MH in Prison guidelines. Does it matter that the scopes vary quite significantly?	Thank you for your comment. IRCs are now not included in the guideline looking at mental health in prisons and the criminal justice system. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline.
101	SH	National	7	P12 – 4.6	Economic Aspects - reference is made in the text to prison service costs.	Thank you for your

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		Offender Management Service			Could this refer to National Offender Management Service Costs as the commissioner of all prisons (both public and privately managed) in England and Wales?	comment, the scope has been amended.
40	SH	NHS England	1	General	Thank you for the opportunity to comment on the above Clinical Guideline. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.	Thank you for your comment.
54	SH	Prison Reform Trust	1	General	We welcome the opportunity to comment on these guidelines and the commitment to improving health care for people in our prisons. Currently, the delivery of health care in prisons is limited by the nature of the environment and not all of these limitations are necessary. Further clarity on matters that involve health care and security such as access to hospital appointments, restraints during medical appointments and medical hold would be welcome. In addition, for most people, prisons are an unhealthy environment and the pressures and deprivations of prison life impact negatively on both their physical and mental health.	Thank you for your comment. The guideline includes health promotion and wellbeing as a key area and will consider environmental and other factors that may impact on physical health.
55	SH	Prison Reform Trust	2		Self harm is not mentioned in the scope. As there have been 23,478 reported/recorded incidents of self harm in prison in the 12 months up to March 2014, with rates among men increasing, and a significant rise in the number of suicides, we would ask that NICE consider bringing this area of work into scope.	Thank you for your comment. Issues relating to the prevention of self-harm will be covered by the NICE guideline on Mental health of adults in contact with the criminal justice system currently in

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						development. This guideline will cover the physical management of prisoners who self-harm as part of the section on emergency management.
56	SH	Prison Reform Trust	3	3.1 e	It is worth noting that the growing number of older prisoners (whilst still a minority of the prison population) have a disproportionate impact on the resources of health care units. The additional health and social care needs of this group, alongside the longer sentence lengths means that many people are in prison for longer and therefore strategies on healthy aging in prisons are urgently needed. This has significant resource implications for both health care and the prison service and guidelines that encourage preventative work will not only help this population directly but reduce the resources needed to care for them in the future, whether in prison or in the community. The Care Act, to be implemented in April 2015 will impact most on those within this group and others in prisons with the severest needs and it could be helpful if this is factored into the guidelines.	Thank you for your comment. We agree. and have included this population as one of special interest.
57	SH	Prison Reform Trust	4	3.2.a	We would welcome the roll out of national screening programmes and would just comment that 'buy-in' from prison staff and prisoners would enable this process to be more effective.	Thank you for your comment.
58	SH	Prison Reform Trust	5	4.1.1	We would suggest including serious and enduing mental illness in the list of people with disabilities. We would add that alongside special consideration for vulnerable groups, a prisoner's specific location in prison can create poor health outcomes, for	Thank you for your comment. Please note that separate NICE guidance is in development on

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					instance, people in segregation experience poorer physical and mental health whilst under segregation.	Mental health of people in contact with the criminal justice system. With regard to prisoner location, NICE is committed to ensuring that its guideline development process fully meets duties under the Equality Act (2010).
59	SH	Prison Reform Trust	6	4.1.1	We understand that end of life care guidelines are being drafted separately. However, as it is not currently possible to provide equivalent end of life care in a prison environment, we would ask that this be taken into consideration in these guidelines and prison specific approaches be considered.	Thank you for your comment. We will cross refer to the NICE guideline 'Care of the Dying Adult', currently in development, which is due to include recommendations relating to prisons.
60	SH	Prison Reform Trust	7	4.1.1	Although there may be challenges in providing long term health care programmes to people on short sentences, we would be concerned about any health care policies that undermine the principle of equivalence and would also caution against making assumptions about how long someone may spend in the criminal justice system.	We agree and will ensure that recommendations give equivalent quality of care to

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						prisoners regardless of length of time in prison. Short-term prisoners are listed for special consideration because they may need different approaches (as it will not be possible for them to use long-term programmes).
61	SH	Prison Reform Trust	8	4.1.1	substance abuse/misuse –see 4.3.1 below	People who have a history of substance misuse are included in the scope as a group for special consideration.
62	SH	Prison Reform Trust	9	4.1.2	Immigration Removal Centres – we would agree that these guidelines should be developed separately but believe that there is a necessity to produce guidelines urgently for this group. We note that while health care in prisons has improved over recent years, this has not happened in IRCs. There is also some overlap between this group (and prisons) and we would like to see continuity of care considered for people who are leaving prison to move abroad, either voluntarily or through deportation processes.	Thank you for your comment. We agree that due to the specific needs of IRCs, these should not be included within this scope.
63	SH	Prison Reform Trust	10	4.1.2	We understand that the mental health guidelines that are being developed in parallel are likely to include police stations, courts and escorts. If a decision is made not to include other parts of the criminal justice system in the	Thank you for your comment. This topic will be covered by

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					physical health guidelines, then it might be helpful to include continuity of care and information sharing processes between prison health care teams and these agencies.	the 'continuity of care' and coordination and communication sections of the scope.
64	SH	Prison Reform Trust	11	4.3.1	Health promotion – alongside the reasons given in the scope, there are significant reasons relating to the environment that often encourage poor health and prevent against access to full health care services. In our experience many prisoners are trying to access health services or develop healthy lifestyles but have difficulties doing this. We would also comment that we believe peer support work to be the most effective way of promoting health and well-being in prisons.	Thank you for your comment. We agree and will be reviewing the evidence on peer support.
65	SH	Prison Reform Trust	12	4.3.1	The immediate task of the reception assessment is to ensure that someone is safe and that any severe or immediate medical needs are managed. The 'churn' of people into prisons means that health care staff do not have the capacity to do full health care assessments at this time and the duty of care is focused on suicide prevention, detox and urgent needs. Continuity of care is problematic without full patient information from community GPs, police stations and courts.	Thank you for your comment.
66	SH	Prison Reform Trust	13	4.3.1	Prescribing and dispensing - diverting medication is hugely challenging in prisons and causes significant security, control and health difficulties. However, diverting medication also happens in the community, and guidelines that encourage safer prescribing across the board, and consistency of practice within the community and in custody would be helpful, In addition, the context of a prison environment, which includes prisoners'	Thank you for your comment. As stated in the scope we will be covering use of medication and will also cross refer to existing NICE guidance on

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					lack of opportunity to buy pain relief over the counter, the impact of little or no activity or alternative forms of support, austere conditions, possible pressures of bullying and coercion and the problems of sometimes being unable to access medication at necessary times all contribute to this situation.	medicines adherence where appropriate.
67	SH	Prison Reform Trust	14	4.3.1.	Guidelines for emergency health responses need to be developed with full participation of the prison service, and a clear understanding of the roles and responsibilities of all staff involved in the care of prisoners. This is particularly important as few prisons now have 24 hour health care provision.	Thank you for your comment. Urgent and emergency health management delivered by prison staff is included in the scope.
68	SH	Prison Reform Trust	15	4.3.1	Transfer –the current transfer system can create difficulties for continuity of care and waste health care resources – including, for example, prisoners needing new hospital assessments or referrals, losing places on hospital waiting lists or moving into an area where they can't get the specialist care they were previously receiving. The current system of 'medical hold' is inconsistently applied and ineffective. We would like NICE to consider this further if possible.	Thank you for your comment. This is be covered by the scope.
69	SH	Prison Reform Trust	16	4.3.1	The responsibilities of agencies involved in care planning for release are currently unclear and guidance on this would be welcome.	Thank you for your comment. Continuity of care on release is included in the scope.
70	SH	Prison Reform Trust	17	4.3.1	Compassionate release –the current provisions for compassionate release for prisoners who are terminally ill or bedridden and severely incapacitated are under used. We would like further guidance for health care staff to be developed.	Thank you for your comment. This topic is outside the remit of this guideline.
71	SH	Prison	18	4.3.2	Health care while in hospital – although prisoners become the responsibility	Thank you for your

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		Reform Trust			of hospital staff whilst inpatients, the risk assessment carried out by prison staff regarding escorts and handcuffs/restraints impacts on quality of care and confidentiality for prisoners in hospital. Prison security staff may not have all the information they need from health care to make a full assessment of the security risk. We would like to see guidance developed so that information is shared.	comment. This guideline will not be reviewing security risks/assessment regarding transfers.
42	SH	Public Health England	1	General	Ensure that the principle of equivalence ..i.e equivalence of access to health care compared to the general populaltion is central to the guideline	Thank you for your comment. An equality impact assessment is undertaken as part of scoping the guideline to identify equality issues to be addressed and to support compliance with NICE's obligations under the Equality Act 2010.
43	SH	Public Health England	2	General	The undertaking of global prison health needs assessments (HNA) would be greatly enhanced / more efficient if recent & representative prevalence data were available for prison populations (rather than using the older prevalence data within the February 2000 Birmingham reference document http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&uact=8&ved=0CCMQFjAA&url=http%3A%2F%2Finsight.oxfordshire.gov.uk%2Fcms%2Fsystem%2Ffiles%2Fdocuments%2FHealth%2520care%2520in%2520prisons.pdf&ei=hsNQVOqOIsHd7gbru4DQBA&usg=AFQjCNFLEnI2HFjsAkkF2bmpZd3QcYsr4Q&bvm=bv.78597519,d.ZGU). If this NICE process could provide an updated evidence base for prisoner	Thank you for this information.

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					morbidity, this would allow for more efficient development of global prison HNA from routine prison demographic data.	
44	SH	Public Health England	3	3.1	Live population data are available on a weekly basis https://www.gov.uk/government/statistics/prison-population-figures-2014	Thank you for your comment.
45	SH	Public Health England	4	3.1d	Provide some examples of how the transfer of commissioning responsibilities to NHS England "expanded the range of healthcare services for people in prison"	Thank you, a sentence has been added to clarify that it was the range of services actually commissioned by NHS England that was expanded.
46	SH	Public Health England	5	3.2 a	Where it says that "national programmes to identify people at risk for some of these conditions and these *could* be applied in prison –change to read "should be applied in prison" (in order to ensure equivalence of access to prevention programmes)	Thank you for your comment. We believe that 'could' is more appropriate for the introduction to the scope of this guideline, so as not to prejudge the results of the evidence reviews that will be conducted for the guideline.
47	SH	Public Health England	6	4.3.1 (Promoting health	Add in the list of description and rationale " Identification of those with risk factors for CVD via the NHS Health Checks"	Thank you for your comment. The NHS Health Check

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				and wellbeing in prisons)		programme is now mentioned in this section.
48	SH	Public Health England	7	4.3.1 (Early health needs assessments)	Add a key clinical issue "What arrangements are best to ensure that NHS Health Checks in prisons are high quality and result in reduction of CVD risk". Under the rationale for this add: " NHS Health Checks in prisons are required by statute and will identify people at high risk of CVD, diabetes and renal disease. Provision to ensure that adequate lifestyle services and clinical services that lead to risk reduction need to be in place and be responsive in order to maximise the effectiveness of the NHS Health Checks. Issues include use of point of care testing; communication of risk; timing of the NHS Health Check in the prisoner's stay; clinical and lifestyle follow through.	Thank you for your comment. Reference to the NHS Health Check programme has now been included. We will not be including this as a key clinical issue in itself, as there is already NICE guidance on conducting NHS Health Checks, which we will cross refer to as appropriate.
49	SH	Public Health England	8	4.3.1 (Promoting health and wellbeing in prisons & Use of Medication)	The use / misuse of medication is included – please add a specific reference to the topic of 'pain management' and associated medication use / misuse?	Thank you for your comment. We understand the importance of this issue, but we will not be including a specific reference to it in the scope as it is covered within the

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						use of medication.
50	SH	Public Health England	9	4.4 Main outcomes	Add a separate outcome: Uptake of NHS Health Checks (because this is not covered by outcome 4.4b as NHS HC is a health promotion programme rather than a screening programme).	Thank you for your comment. Specific details of reviews, including the outcomes for each review, will be detailed within the review protocols.
51	SH	Public Health England	10	4.5d	Add. How should these subsequent health assessments coordinate with the mandated NHS Health Checks/	Thank you, this is within the scope of the questions relating to health assessments.
52	SH	Public Health England	11	4.5h	Add. What are the most effective means of ensuring that those on the LTC registers and on the high CVD risk register receive high quality annual checks as required under QOF	Thank you for your comment. This will be considered as part of monitoring chronic conditions.
53	SH	Public Health England	12	4.5j	Add in particular effectiveness of continuity of care with general practice and with health improvement services run by the local authority.	Thank you for your comment. These come within community services and so will be included in the consideration of continuity of care.
38	SH	Royal College	1	General	I agree with the importance of the topic area. Consideration should be given to setting up a James Lind Alliance topic area and developing research	Thank you for your comment. We will

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		of General Practitioners			questions with NIHR.	follow established NICE procedure for making research recommendations where appropriate during development of the guideline.
39	SH	Royal College of General Practitioners	2	4.5	Consideration should be taken to expand 4.5; Review questions: What are the effects of prison environment and overcrowding on health and what changes are cost effective? What are the health needs of the rising elderly prisoners population and effective interventions? What are the health problems unique to women prisoners and the knock-on effect on prisoners' families? How can improvements be made to recruitment and retention of well-qualified health professionals and how to gain the professional independence? How much can the UK learn from developments in other European countries that are among the 45 members of the World Health Organization (Europe) Health in Prisons Programme (www.euro.who.int/prisons)? Does international benchmarking of health indices in prison improve health care outcomes?	Thank you for your comment. Prioritisation and drafting of final review questions will be completed in conjunction with the guideline development group based on the key clinical issues listed. The group will consider the questions provided and also refer to existing NICE guidance where relevant.

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					How effective is a needle and syringe exchange service available in prisons? Are community orientated facilities conducive to the rehabilitation of prisoners? How effective is motivational interviewing in prisons? How can prisoners be encouraged to take greater responsibility for improving their health and habits?	
35	SH	Royal College of Nursing	1	General	The Royal College of Nursing welcomes proposals to develop this guideline. The draft scope looks fairly comprehensive.	Thank you for your comment.
36	SH	Royal College of Nursing	2	4.2	We would strongly recommend that the Immigration and Removal Centres and police custody healthcare are in scope of this work particularly as these areas form an integral part of the CJS pathway and their inclusion will be of relevance. We feel that whilst NICE have invited focus on prisons specifically we believe that a fuller pathway approach is better and would be reluctant to see these areas excluded.	Thank you for your comment. Stakeholders have advised that there are important differences between IRCs and prisons. Since IRCs are not prisons they are outside the remit for this guideline. For these reasons IRCs have not been included in the scope of this guideline

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37	SH	Royal College of Nursing	3	4.3.1	There seems to be an absence of mention for the need to have strong nursing leadership. Given that the RCN believes that nursing delivery forms a significantly large part of the overall CJS workforce it would seem sensible to address this issue in particular. Sustainability , succession planning and leadership are all areas which will need attention for safe and effective delivery of services	Thank you for your comment. The composition of the guideline development group will include a number of members with nursing expertise.
41	SH	Royal College of Physicians	1	General	The RCP is grateful for the opportunity to respond to the draft scope. We believe it is important work and would like to congratulate NICE for taking it forward. Although, the RCP is not best placed to comment on the entire document we do wish to comment from the perspective of health inequalities and in particularly the effects of homelessness on health. We would like to make the following points: • 15% of prisoners are homeless prior to imprisonment. Of these 79% will reoffend on discharge from prison; compared to 47% of those who were housed prior to offending • Those with drug and alcohol problems find it particularly hard to find housing on discharge • The trimorbidity of homelessness, mental ill health and substance misuse contribute to an average age of death of 44 years. • We believe that all offenders should be found accommodation prior to discharge • Offenders should also be registered with a GP prior to discharge • All offenders who are enrolled in drug and alcohol services within prison should have an appointment made with community drug and alcohol services within 24 hours of discharge • Alongside support with social needs (eg post-release housing and	Thank you for this information.

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					employment) and mental health needs (eg substance misuse), it is vital that the physical health of people in prison is also supported. • People in prisons should be supported to improve their health and avoid bad health through access to effective health improvement services which are tailored to meet the specific needs of the prison population. This should include support such as smoking cessation, advice and brief interventions on alcohol consumption, weight management, sexual health screening, and mental wellbeing services. • Given the high proportion of people in prison who were previously homeless, it is important that all those working with the prison population understand the specific health needs associated with homelessness. The RCP endorses the Faculty of Homeless and Inclusion Health's Standards for commissioners and providers http://www.pathway.org.uk/wp-content/uploads/2014/01/Standards-for-commissioners-providers-v2.0-INTERACTIVE.pdf as a guide to support staff to understand and provide for these needs. The Faculty of Homeless and Inclusion Health should be specifically involved within the NICE guideline process	

These organisations were approached but did not respond:

2gether NHS Foundation Trust
5 boroughs NHS Foundation Trust Partnership
Abbey Community Association Ltd
AbbVie
Action on Smoking and Health
Advertising Standards Authority
Age UK
Age UK North Tyneside
Alcohol Concern
Allocate Software PLC

Alzheimer's Society
ASPECT
Association of Anaesthetists of Great Britain and Ireland
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Directors of Public Health
Association of Police and Crime Commissioners
Belfast Health and Social Care Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham City Council
Black and Ethnic Minority Diabetes Association
Bolton Council
Bracknell Forest Council
Bristol City Council
British Academy of Audiology
British Association for Sexual Health and HIV
British Association for the study of Community Dentistry
British Dental Association
British Heart Foundation
British Institute of Learning Disabilities
British Liver Trust
British Medical Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Pain Society
British Psychological Society
British Psychological Society
British Red Cross
British Retail Consortium
British Society for Disability and Oral Health
Brunel University
Calderstones Partnerships NHS Foundation Trust
Cambridge University MRC Epidemiology Unit
Cambridgeshire & Peterborough NHS Foundation Trust
Camden Public Health NHS NCL London
Cancer Research UK
Capsulation PPS

Cardiff School of Social Sciences
Care Plus Group
Care Quality Commission
Central & North West London NHS Foundation Trust
Central and North West London Sexual Health Services
Centre for Policy on Ageing
Centre for Reviews and Dissemination and Centre for Health Economics – York
Chartered Society of Physiotherapy
Cheshire & Wirral Partnership NHS Trust
Cheshire West and Chester Council
Citizens Commission on Human Rights
City of Lincoln Council
Cochrane Drugs and Alcohol Group
Cochrane Heart Group
Cochrane Oral Health Group
Cochrane Public Health Group
Cochrane Tobacco Addiction Group
College of Occupational Therapists
College of Optometrists
Contact
Croydon Council
Cumbria Partnership NHS Foundation Trust
CWHHE Collaborative CCGs
Darlington Borough Council
Defence Public Health Unit
Department for Work and Pensions
Department of Health
Department of Health, Social Services and Public Safety - Northern Ireland
Deputy Parliamentary & Health Service Ombudsman
Diabetes UK
Dietitians in Obesity Management UK
DNU Health Protection Agency
Doncaster Council
DrugScope
Dudley Office of Public Health
Durham County Council
East of England Public Health Group
East Riding of Yorkshire Council

Economic and Social Research Council
Edinburgh School of Social Sciences
Equalities National Council
Faculty of Forensic and Legal Medicine
Faculty of Occupational Medicine
Faculty of Public Health
Faculty of Sport and Exercise Medicine
False Allegations Support Organisation
Food Inside Out
Food Standards Agency
Gloucestershire LINk
Greater Manchester West Mental Health NHS Foundation Trust
Hampshire County Council
Harrogate and District NHS Foundation Trust
Health and Care Professions Council
Health and Safety Executive
Health and Social Care Information Centre
Health Research Forum
Healthcare Improvement Scotland
Healthcare Quality Improvement Partnership
HealthWatch England
Healthwatch Peterborough
Heart of Mersey
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Prisons
Hertfordshire County Council
Hertfordshire Partnership NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Humber NHS Foundation Trust
Hyperactive Children's Support Group
INQUEST
Institute of Alcohol Studies
Isle of Wight Council
Janssen
Joint Committee on Vaccination and Immunisation
Lancashire Care NHS Foundation Trust
Leeds City Council
Leeds Metropolitan University

Leicestershire Fit for Work Service
Leicestershire Partnership NHS Trust
Lilly UK
Lincolnshire County Council
Lincolnshire Partnership NHS Foundation Trust
Liverpool City Council
Local Government Association
London Borough of Newham
London Development Centre
London Joint Working Group on Substance Misuse and Hepatitis C
London TB Clinical Reference Group
Making Waves
Medical Foundation for AIDS and Sexual Health
Medical Research Council
Medicines and Healthcare products Regulatory Agency
Medsin
Medway Public Health
Mental Health Group - British Dietetic Association
Merton Council
Mind
Ministry of Defence
MTS Medication Technologies Ltd
National AIDS trust
National Association of LINk Members
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Commissioning Board
National Deaf Children's Society
National Institute for Health and Care Excellence
National Institute for Health Research
National Obesity Forum
National Offender Management Service
National Public Health Service for Wales
Nestor Primecare
Newcastle University
NHS Ayrshire and Arran

NHS England
NHS Hardwick CCG
NHS Health at Work
NHS Health Scotland
NHS Improving Quality
NHS Oldham CCG
NHS Plus
NHS Sheffield CCG
NHS South Gloucestershire CCG
NHS West Cheshire CCG
NIHR Greater Manchester Primary Care Patient Safety Translational Research Centre
North Essex Partnership Foundation Trust
North of England Commissioning Support
Northern Health and Social Care Trust
Northumberland Care Trust
Nottingham School of Social Sciences
Nottinghamshire Healthcare NHS Trust
Nursing and Midwifery Council
Offender Health Research Network
Office of the Police and Crime Commissioner - Northumbria
Office of the Police and Crime Commissioner - South Wales
Older People's Advocacy Alliance
Oxleas NHS Foundation Trust
PARITY
Peterborough City Council
Physiotherapy Pain Association
Plymouth City Council
POhWER
Positively UK
Primecare
Prison Reform Trust
Public Health Agency
Public Health Bolton
Public Health England
Public Health Manchester
Public Health Portsmouth
Public Health Wales NHS Trust
Public Health Wales NHS Trust

Public Health Wandsworth
QUIT
Re-Solv
Rethink Mental Illness
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Psychiatrists in Scotland
Royal College of Psychiatrists in Wales
Royal College of Radiologists
Royal College of Speech and Language Therapists
Royal College of Surgeons of England
Royal Cornwall Hospitals NHS Trust
Royal Pharmaceutical Society
Royal Society for Public Health
Royal Society of Medicine
Runnymede Trust
Scientific Advisory Committee on Nutrition
Scottish Intercollegiate Guidelines Network
Sefton Council
Self Management UK
Sheffield City Council
Sheffield Teaching Hospitals NHS Foundation Trust
Smokefree Bristol
Social Care Institute for Excellence
Society of Local Authority Chief Executives and Senior Managers
Soldiers, Sailors, Airmen and Families Association
Somerset County Council
Sophia Forum

South Belfast Partnership Board
South Eastern Health and Social Care Trust
South Gloucestershire Council
South West Yorkshire Partnership NHS Foundation Trust
Southern Health & Social Care Trust
St Andrews Healthcare
St Helens Council
Staffordshire and Stoke on Trent Partnership NHS Trust
Staffordshire County Council
Stockport Clinical Commissioning Group
Suffolk County Council
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
TB Alert
TDI
Tees, Esk and Wear Valleys NHS Trust
Terrence Higgins Trust
Thames Reach
The Centre for Workplace and Community Health
The Chartered Institute of Environmental Health
The Institute of Osteopathy
The Journal of Public Mental Health
The Surrey Local Involvement Network
The Vegan Society
Therapy in Praxis
Tobacco Control Collaborating Centre
UK CAB
UK Health Forum
UK National Screening Committee
UK Public Health Register
UK Society for Behavioural Medicine
Unite - the Union
University College London Hospital NHS Foundation Trust
University of Central Lancashire
University of Glasgow
University of Manchester
University of Wolverhampton
University of Worcester

Uscreates
Victim Support
Warwickshire County Council
WAVE Trust
Welsh Assembly Government
Welsh Government
Welsh Scientific Advisory Committee
West London Mental Health NHS Trust
Western Health and Social Care Trust
Wigan Borough Clinical Commissioning Group
Women in Prison
Youth Justice Board for England and Wales