PUBLIC HEALTH PROGRAMME GUIDANCE – CARDIOVASCULAR DISEASE

Consultation on the Draft Guidance – Stakeholder Response Table

Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Action Heart		General	It is suggested that 'education' begins at home with the parents prior to formal education during school years. How do we educate the parents? Car parking charges for employees - Although the logic of this idea is easy to follow it is perhaps likely to result in a hidden tax for employers as opposed to an incentive for employees.	Thank you. This guidance focuses on population level recommendations to address CVD. Subsidising car parking discourages public transport, cycling and walking and so potentially reduces levels of physical activity.
Arrhythmia Alliance		General	References to cardiac arrhythmias - • sudden cardiac death leads to 100,000 deaths in the UK each year • Atrial Fibrillation (AF) is a leading cause of stroke, • AF is expensive -to the NHS, is commands 1 % of the total NHS annual budget. • At the age of 40, we all have a 1 in 4 life time risk of developing AF. • 150,000 strokes per year in the UK, 410 per day, 17 per hour, so in a two hour meeting, 5 patients with AF have suffered a stroke,4 would have been known to be high risk of stroke • The annual cost of stroke to the UK economy is £8.9 billion – that is £44,000 per stroke victim (Saka et al, 2009). So detecting AF and reducing the risk if stroke by effective management is VERY cost efficient.	Thank you. The cost of stroke to the UK is included in the economic modelling, and the overall cost of CVD referenced in section 2. However detection of AF is outside the scope of this guidance

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Arrhythmia Alliance		General	Patient access to information and support is crucial - third sector groups and organisations can provide a primary route towards this. Preventative tools such as health checks including weight, blood pressure and pulse checks can be self-taught and self-managed. Pulse checks can be used to detect potential cardiac arrhythmias, but are also an important part of keeping a healthy lifestyle. Pulse checks should also fit into the broader government health checks and performance framework. They also reflect your recommendation for a 'whole population' approach, to identify those not already classified in a risk group. Wider publicising of simple health check procedures.such as pulse checks to both individuals, patients and medical professionals will lead to their uptake. C collaboration on the provision of services and the direction of policy is key - it is crucial to have a joined up approach involving policy makers, health institutions, allied professionals and charitable organisations. Mention the NSF Chapter 8 on the addressing of cardiac arrhythmia services. The funding and infrastructure for locally enhanced services aimed at prevention should be in place.	This guidance is concerned with primary prevention of CVD including the primary prevention of arrhythmia. Identification and management through for instance the NHS health checks programme is complementary to this but is outside the scope of this guidance.

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Association of Bakery Ingredient Manufacturers		General	Association of Bakery Ingredients Manufacturers (ABIM) welcomes the opportunity to comment on the NICE Draft recommendations on the prevention of cardiovascular Disease. ABIM members represents the common interests of UK companies who manufacture and supply a wide range of ingredients and associated products to the baking industry and this will be the focus area of our response.	Thank you.
Association of Bakery Ingredient Manufacturers		Rec 4: Saturated Fat	It is important to remember that the bakery industry requires the use of saturated fats in their products for reasons such as functionality proposes, to help create the structure, texture and flavour of a product. Also bearing in mind the loss of other options to the industry such as trans-fats and emulsifiers which limits the ability for development and innovation. Any change to a product, however large or small, comes with significant technical, financial and consumer challenge that companies have to over come.	The PDG is aware of the many roles of saturated fats, and that changes will present technical challenges. However there are considerable public health benefits to be gained from supporting and continuing such changes.

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Association of Bakery Ingredient Manufacturers		Rec 5: Trans fats	ABIM would not support the necessity to ban the use of industrial trans fats for human consumption throughout the EU. We are content that our sector, under the monitoring of FSA, is already committed to reducing trans-fats in food production. A review by the Scientific Advisory Committee on Nutrition (SACN) in November 2007 on behalf of the Food Standards Agency has estimated the average intake of trans fats in the UK adult diet to be a maximum of 1% of total energy intake[i]. This is a reduction from the previous figure of 1.2% in a 2000/2001 survey and is well below the figure of 2% recommended by SACN. ABIM are content that current Trans Fats levels are not a cause for concern. EFSA also note in their report on dietary reference values[1]; that UK average intake has reportedly halved in recent years owing to the reformulation of many products. The effect that TFAs have on Cardiovascular health is significantly reduced in the UK owing to the fact that intake levels are currently below 1% of total food energy well below levels in many other countries.	The PDG was aware of the position taken by the FSA and SACN that intake of IPTFAs is at a level that does not constitute a significant health threat. However, the PDG was of the view that there are groups in society that consume IPTFAs at higher (and probably considerably higher) levels. They believed that it is important to protect this group from what are widely believed to be unnecessary toxic ingredients. Achieving this protection by regulation would also help provide a level playing field for all commercial organisations and would help address IPTFAs at an international (EU) level. The committee was aware of the risks of substitution with saturated fats and that this would have adverse health effects. This is addressed in the recommendation

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Association of Bakery Ingredient Manufacturers		Rec 5: Trans fats	Given the positive steps already taken by industry to reduce Trans Fats levels and the current advice of EFSA and the FSA, we consider there is no need to impose a ban as this would dis-proportionate with the desired benefits. This opinion is further strengthened by the European Food Safety Authority EFSA which published its draft opinion on dietary reference values for Fat on the 5th August 2009. http://www.efsa.europa.eu/EFSA/efsa_locale1178620753812_1211902774897.htm In its Opinion the EFSA panel recommend the following: *'Dietary TFA are provided by several fats and oils and are also important sources of essential fatty acids and other nutrients. Thus there is limit to which intake of TFA can be lowered without compromising adequacy of intake of essential nutrients. Therefore, the panel recommends that TFA intake should be as low as possible within the context of a nutritionally adequate diet'.* [1] EFSA- Dietary Reference Value For Fat 2009 http://www.efsa.europa.eu/EFSA/efsa_locale1178620753812_1211902774897.htm	Please see comment above

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Association of Bakery Ingredient Manufacturers		Rec 2: product labelling and marketing	**Costs** Overall any change made to a product incurs many costs, from the research and development phase thought to the bakeries and ingredient suppliers. Large costs are also incurred with packaging changes for labelling and data sheets. These costs are also seen within the distribution area, which could mean a shorter shelf-life for a product and potential microbiological issues, which could in turn create waste. Additional costs would be incurred when any raw materials are changed and for example higher costs if more liquid oil, more complex hard fat fractions and fat replacers were used. These changes could have a knock on effect and slow down production and heighten the need for new or modified equipment. It needs to be recognised that a small business may not be able to cope with all these additional costs. **Legislation** The significant cost of reformulation is difficult for producers to recoup if no claim on pack is possible under the EU Nutrition and Health Claims Regulation (EC) No.1924/2006. Are NICE pursuing a 'heart friendly claim' with the EFSA that would support manufactures in these changes?	The PDG is aware that there are many practical and logistical issues in changes to formulation, labelling etc. However the establishment of the integrated FSA traffic light front of pack labelling as the national standard (as in recommendation 6 in the final guidance) would provide a level playing field which would clarify the issue for manufacturers, retailers and consumers. It is not within the remit of NICE to pursue 'heart friendly claims' with the EFSA

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Association of Bakery Ingredient Manufacturers		Rec 2: product labelling and marketing	Ref: [1] Update on trans Fatty Acids and Health – Position statement by the Scientific Advisory Committee on Nutrition 2007.	Thank you. The recommendations on IPTFA are now covered by recommendation 3. The PDG was aware of the position taken by the FSA and SACN that intake of IPTFAs is at a level that does not constitute a significant health threat. However, the PDG was of the view that there are groups in society that consume IPTFAs at higher (and probably considerably higher) levels.
Bournemouth University		1 and 2	In relation to fat and salt intake the use of `incentives` and `persuasion` techniques to reduce the amount of salt and fat in prepared foods does not comply with the evidence you have referred to yourselves in this area which is based on legislation or dramatic reductions in intake. Your recommendations should be based on the evidence not softened for the benefit of industry.	Recommendations 1 and 2 (on salt and on saturated fats) include a variety of methods to reduce intake.
British Frozen Food Federation		General	Our interest as a trade association operating in the food sector is naturally with those sections of the guidance that relate to food standards, nutrition and diet.	Noted.
WhBritish Frozen Food Federation		General	We are particularly disappointed that the draft guidance shows no evidence whatsoever that there has been any 'joined-up' approach across government departments during this project, and there seems to be no recognition of many developments that are already underway.	Thank you. The PDG is aware of activity in relevant areas. Government departments were involved in commenting.

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British Frozen Food Federation		General	There is for example no reference to, or acknowledgement of, the 'Food Matters' report from the Cabinet Office, which assigned lead responsibility across a wide range of issues. Nor is there any reference to 'Healthy Weight, Healthy Lives', described at the time of publication as a cross-Government strategy for England. 'Healthy Weight, Healthy Lives' has an associated Healthy Food Code of Good Practice where the Department of Health and the Food Standards Agency (and other government departments) have lead responsibilities on different aspects of the strategy.	These reports are referenced in section 2 and elsewhere in the report.
British Frozen Food Federation		General	All of this (and much more) must be highly relevant to any consideration of 'prevention of cardiovascular disease at the population level'.	Thank you.
British Frozen Food Federation		General	There also seems to be at best a limited appreciation of how the EU has the lead responsibility in many areas related to the food sector, in legislation and standards for example.	Thank you. The role of the EU is important, however NICE is not able to make recommendations to the EU.
British Frozen Food Federation		General	Our comments are mostly at this general level, as it seems to us that there is a serious need to totally revisit any recommendations related to food standards, nutrition and diet, both to reflect the reality of ongoing developments and to provide an opportunity for a genuinely joined-up approach at the government level.	The PDG feel that the recommendations are robust and address areas where there is substantial premature mortality.

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British Frozen Food Federation		Recommendation 2 (Labelling)	The future of food labelling in the short to medium term will be determined by EU initiatives, for example the current food information proposal The possible role for national schemes alongside new European requirements remains unclear	The guidance (recommendation 6) recommends the use of the Food Standards Agency's integrated front of pack label for products sold in England as the national standard. It also recommends that the UK continues to set the standard of best practice by leads Europe, by ensuring the Food Standards Agency pursuing obtains exemption from potentially less effective EU food labelling regulations when appropriate
British Frozen Food Federation		Recommendation 3 (Salt)	Sodium (salt) reduction is an area where the food industry has achieved much and where the issues associated with further progress are understood, but not acknowledged in the draft guidance	Thank you. This is acknowledged in the final guidance. However, the PDG feel that further and faster progress is needed to address the substantial burden of premature mortality associated with CVD.
British Frozen Food Federation		Recommendation 4 (Saturated fats)	There is an existing target level for saturated fat in the UK diet and the FSA has an active strategy in this area. The target was based on expert recommendation, made specifically in the context of the UK.	The PDG is aware of the existing target for saturated fat. However there are potential additional benefits from reducing saturated fat consumption further.
British Frozen Food Federation		Recommendation 5 (Trans fats)	Again, the draft guidance does not seem to take any account of expert advice that has been provided to government, specifically relating to the situation in the UK. Where an expert advisory committee (SACN) has provided such advice to government, this should not be ignored.	The PDG is aware of the recommendation from SACN. However, the PDG felt that it is important to provide protection to those groups that currently consume higher levels of IPTFAs

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British Heart Foundation		General	The British Heart Foundation (BHF) is the UK's leading heart charity, fighting to eradicate early death from heart and circulatory disease – which is the UK's biggest killer and caused 53,000 premature deaths in 2006[2]. Our vision is of a world in which no-one dies prematurely of heart disease. We welcome the opportunity to respond to this consultation and to help develop NICE guidance in this area. The BHF's engagement in public health issues is broad ranging and we are committed to improving the cardiovascular health of the nation through increased awareness of the benefits of a healthy lifestyle, advocating for the right environment to make the healthy choice the easy choice and providing a range of information and support for people at risk of or living with heart disease. If you have any queries about this response, or would like any further information, please contact Mubeen Bhutta, Policy Manager on 020 7554 0158 or email bhuttam@bhf.org.uk	Thank you.
British Heart Foundation		General	The title of this guidance is potentially a misnomer as it largely concentrates on nutrition issues. While the rationale for this – that there is existing NICE guidance relating to other risk factors such as physical activity and tobacco – is clearly explained in the document, this is not reflected in the title and could therefore be misleading.	Thank you. The guidance acknowledges that there are other risk factors, many of which have been addressed in other NICE guidance. The title for the work is taken from the referral from DH.

[2] See www.heartstats.org

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British Heart Foundation		General	The guidance contains 24 recommendations in a range of areas where action has been identified. While this breadth is welcome, it would be useful to have some sense of prioritisation about which recommendations are most important or require the soonest implementation. This will help to ensure that progress is made on key areas and that organisations such as the BHF who are committed to improving the cardiovascular health of the nation can focus their resources and influencing activities appropriately.	Thank you. The PDG discussed issues relating to prioritisation of the recommendations. They felt that this was difficult to achieve as many organisations will prioritise issues differently depending on their roles and activities. The guidance is not aimed at a single group. However, the guidance notes the importance of addressing the policy issues highlighted.
British Heart Foundation		General	It would be useful for the final guidance to be clear about application and jurisdiction. In several places the consultation document refers to 'the government' but it is unclear which administration this means especially as some of the examples used in the document are from Scotland. This is perhaps particularly important given the cardiovascular health inequalities between different nations of the UK.	Thank you. NICE guidance is produced for England but is likely to be of relevance to the other nations of the UK and more widely.

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British Heart Foundation		General	The BHF is concerned about gaps between NICE guidance and actual practice from local providers and commissioners. This was recently highlighted by the Care Quality Commission report *Closing the gap: tackling cardiovascular disease and health inequalities in England by prescribing statins and stop smoking services*. The report found that CVD prevention by primary care providers has not been undertaken in a planned, focused and consistent way in line with DH and NICE guidance. We therefore believe that NICE should set out key implementation mechanisms alongside the final guidance and hold those identified for action to account for translating proposals into practice. As the nation's heart charity, the BHF also has a key role to play in ensuring that all patients are receiving consistent, quality care in line evidence based guidance.	Thank you. Implementation is a key issue with all NICE guidance. Implementation tools will be produced with the guidance, although currently NICE's role does not include holding organisations to account for implementing recommendations.

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British Heart Foundation		Page 5	The BHF welcomes the inclusion of the Cardio and Vascular Coalition's (CVC) strategy document *Destination 2020* in this consultation document. However, it would be useful for the final guidance to include a fuller explanation of the aims of the CVC and how these relate to the objectives of this guidance. The CVC is an alliance of 41 voluntary organisations, chaired by the BHF, who have come together to call for a renewed strategic approach to tackling all cardiovascular disease in England. The tenth anniversary of the National Service Framework for Coronary Heart Disease Service is an opportune moment to consider the challenges for the coming decade. The CVC has identified prevention as one of the key pillars of a refreshed strategic approach, and this should be at the heart of planning for future services. The CVC's recommendations in this area include training and support to help commissioners deliver evidence-based prevention and health promotion programmes, incentive schemes to help implement prevention measures and social marketing programmes to increase awareness of risk factors and encourage behaviour change.	Thank you. The PDG agree that the CVC strategy document is important. However it is not possible to include a fuller explanation of the aims of the CVC in the current document.
British Heart Foundation		Page 5	A copy of Destination 2020 is included with this submission.	Thank you.

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British Heart Foundation		Page 11, paragraph 3.9	The BHF believes that a range of measures at both population and individual level are needed to ensure CVD prevention. While this guidance rightly focuses on the population level, this should not be at the expense of suggesting that policymakers and service providers should not also concentrate on smaller numbers of people at higher risk.	Thank you. We agree that both approaches are useful and complementary, however the focus of this guidance is on population level interventions. Other guidance addresses the needs of high risk groups.
British Heart Foundation		Page 14, paragraph 3.16	The BHF welcomes the inclusion of the role that voluntary and community groups have to play in the consultation document. We make a number of contributions to prevention of cardiovascular disease including pioneering research, advocating for the right environment to make the healthy choice the easy choice and providing information and advice at both the population and individual levels. We also submitted a paper on the role of social marketing in improving public health to the previous consultation on evidence for prevention of cardiovascular disease. This is an important role play by voluntary sector organisations.	Thank you.

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British Heart Foundation		Page 15, paragraph 3.17	The consultation document talks about meeting the needs of 'deprived groups'. Whilst it is unclear which groups are being referred to, this term suggests groups that are socioeconomically disadvantaged. Although people from particular socioeconomic groups are at disproportionate risk of developing cardiovascular disease, it is important to consider a range of other factors that contribute to cardiovascular health inequalities including ethnicity and gender. The BHF commends the suggestion that community leaders could be engaged in delivering CVD prevention. In 2007, we ran a social cooking project where dieticians worked with Sikh Gurdwaras and Hindu Mandirs to help them reduce the salt content in the food they provide to worshippers. We also used the ethnic minority media and other promotional materials to get the message out and produced a healthy recipe book to help South Asians cooking at home. There was a reported overall 10 per cent salt reduction in all cooking in places of worship and most also started using less fat. This project was funded by the Food Standards Agency and is a good example of working with the community to address health inequalities in cardiovascular disease prevention.	Thank you. This paragraph (now 3.66) is intended to include groups that experience worse health, such as some ethnic groups. Recommendation 14 also include identifying and addressing the needs of groups who are disproportionately affected by CVD

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British Heart Foundation		Page 19, paragraph 3.29	The inclusion of calorie labelling was part of a recent consultation from the Food Standards Agency. The outcome from this should be reflected in the final guidance from NICE. The BHF believes that consumers need to have fuller information about the nutritional content of food as weight is not the only issue in relation to heart health. This is why the BHF has long championed consistent labelling of all four key nutrients.	Thank you. The PDG feel that the provision of clear information understandable at a glance by everyone is important. The recommendations (number 6) include the implementation of a single universal FOP traffic light coloured labeling system to achieve this aim.
British Heart Foundation		Page 19, paragraph 3.30	The BHF's forthcoming publication, *Couch Kids: Getting our kids off the couch and why it matters*, also confirms that sedentary behaviour is an area where further research is needed. This is particularly the case for the detriment of sedentary behaviour irrespective of physically active periods. A recommendation from the new BHF report is for more investment in research in this area, which could be usefully echoed by NICE in this guidance.	Thank you. The PDG agree that sendentary behaviour is important. The guidance says 'However, evidence on how to address sedentary behaviour is not well developed and remains an area for further study.'
British Heart Foundation		Page 19, paragraph 3.32	The CVC has identified prevention in children as a key area requiring attention in the coming decade. In particular, Destination 2020 calls for childhood prevention strategies aimed at tackling smoking, increasing physical activity and improving diets.	Noted.

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British Heart Foundation		Page 23	The consultation document includes a range of people who should take action including Ofcom. This should be extended to include the Advertising Standards Authority who is a key player in terms of regulating food marketing. A number of the areas covered by the recommendations relate to European Union policy and competencies. It would therefore be useful for this section to include detail on how they will be expected to take account of this guidance.	Thank you. The ASA are included in the list of stakeholders for the policy recommendations.
British Heart Foundation		Page 25, recommendation 1	It would be useful for this recommendation to clarify whether the fiscal incentives and disincentives envisaged would be set at UK or EU level. The final guidance should also clarify how this recommendation relates to the research that the Department of Health are commissioning on the impact of price on calorie consumption[3]	This bullet point (now part of recommendation 2) has been altered. The final text is 'Create the conditions whereby lower –saturated fat products are sold more cheaply than high – saturated fat products. Consider legislation and fiscal levers if necessary'. NICE is not in a position to make recommendations directly to the EU.

[3] https://www.nihr-ccf.org.uk/site/docdatabase/prp/prp_cp_docs/Calories%20Pricing_Research%20Spec_v4.pdf

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British Heart Foundation		Page 25, recommendation 2	The consultation document suggests that product labelling affects consumer behaviour. The BHF believes that clear and consistent labelling provides consumers with the information that they need to make genuine choices. While this may lead to them making healthier choices, the rationale for such a policy intervention must be empowering consumers rather than mandating behaviour. The recommendation suggests that legislation should be introduced to implement a single front of pack labelling scheme in England. Our understanding is that a mandatory labelling scheme can only be introduced at a European level and so initiatives at national level would remain necessarily voluntary. We would also be concerned about any particular stipulations for England – labelling must be consistent as far as possible to empower consumers and should certainly be consistent across the UK.	The remit of NICE is to produce guidance for England rather than for the UK as a whole. The PDG agree that the influence of the European level is important, but that England 'set the highest standards of food labeling regardless of practices in other jurisdictions. Specifically, ensure the UK continues to set the standard of best practice by leads Europe, by ensuring the Food Standards Agency pursuing obtains exemption from potentially less effective EU food labelling regulations when appropriate' (recommendation 6)

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British Heart Foundation		Page 25, recommendation 2	The consultation refers to 'the Food Standards Agency's Integrated Label' but the single integrated model was confirmed as the best scheme to meet the needs of the whole population by independent research commissioned by the Food Standards Agency. It is important that this distinction is upheld to demonstrate the integrity of the findings. The recommendation suggests that advertising of amber and red products should be restricted. Taking such a blanket approach will also restrict the advertising of some healthier foods which as classified as amber or red such as oily fish or porridge oats. It would therefore be beneficial to refine this recommendation to ensure that it is appropriately targeted.	Thank you. The final guidance uses the term 'single universal FOP traffic light coloured labeling system'. The bullet referring to restriction of advertising for amber and red products has been deleted.

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British Heart Foundation		Page 25, recommendation 2	While this may make a helpful addition to the current restrictions on marketing of foods high in fat, sugar and salt, it is important that these restrictions relate to the protection of children from unhealthy food marketing The BHF believes that the best way of protecting children from unhealthy food marketing is the introduction of a ban on advertising of foods high in fat, sugar and salt on broadcast media before the 9pm watershed. The current restrictions do not go far enough as HFSS foods are still marketed during programmes that are popular with children and where they form a significant part of the audience. We are concerned about the inclusion of a separate statement in this recommendation about salt. This should be picked up through a single, consistent front of pack food labelling scheme and not subject to a separate recommendation in this way.	Thank you. The final guidance (recommendation 4) now says 'extending the TV advertising scheduling restrictions on foods high in fat, salt or sugar (as determined by the Food Standards Agency's nutrient profile) up to the 9pm' The separate statement about salt has been deleted.
British Heart Foundation		Page 26, recommendation 3	It is unclear how reducing population salt intake is an action. This seems, rather, the objective of the recommendation.	Thank you. The final guidance includes actions to achieve this objective.

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British Heart Foundation		Page 27, recommendation 5	The BHF welcomes the proposals to improve monitoring of trans fat consumption. We remain concerned that much of the information in this area, especially in terms of the current levels of trans fats in food products, is self-reported by the food industry, often by the overarching bodies representing individual companies within each individual sector. Although we have no reason to doubt the testimony of these bodies, they have a clear interest in ensuring that regulation of the sector is as light as possible. As there is so little evidence on the level of trans fats in the UK diet, we believe that this is something the Food Standards Agency should explore, in a way that could identify differences between the nations of the UK, and with particular cognisance of any potential impact on health inequalities. This could comprise an independent evaluation of the trans fat contents of a sample range of products, in consultation with, but autonomous of, the food industry. Such a review could then inform voluntary targets to reduce the level of trans fats in the UK across all food groups, if needed.	The PDG felt that there is an imperitive to protect those in the population who consume high levels of IPTFA. The actions to achieve this include legislation to ensure IPTFA levels in the fats and oils used in food manufacturing and cooking do not exceed 2%.

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British Heart Foundation		Page 28, recommendation 6	The BHF agrees that public sector organisations have a key role to play in providing nutritious food and drink. We recently published a new report, *A Fit Choice? A campaign report on the provision of children's food in leisure venues* which uncovered the lack of healthy options in venues where children go to get active. This is particularly concerning as a missed opportunity to join up physical activity and a healthy diet. We are therefore calling on public sector providers and contractors to ensure that healthy options are available in such venues. This could make a useful addition to this recommendation. A copy of the report is included with this submission. The Healthier Food Mark scheme has been set up to reward and encourage best practice from public sector organisations. There is some evidence to suggest that the Healthy Living Award run by Consumer Focus Scotland has paid dividends through a voluntary approach. Rewarding good practice should therefore remain the focus for the Healthier Food Mark.	Thank you. Recommendation 10 calls for public sector providers to meet FSA approved dietary guidelines. Recommendation 19 includes the provision of healthier options at venues where public money is spent, including sports centres. The recommendation says 'When public money is used to procure food and drink in venues outside the direct control of the public sector, ensure those venues provide a range of affordable healthier options (including from vending machines). Ideally, the healthier options should be cheaper than the less healthy alternatives. For instance, carbonated or sweetened drinks should not be the only options and fruit and water should be available at an affordable price. (Examples of when public money should be used in this way include school visits to museums, sports centres, cinemas and fun parks.)'
British Heart Foundation		Page 28, recommendation 7	The BHF welcomes the proposal to ensure that local authorities use their planning powers to control fast food outlets. It would be useful for this recommendation to also include proposals for local authorities to map existing fast food provision in their local area, which would help inform future decisions.	Thank you. This is now recommendation 11. Recommendation 21 also says 'use existing powers to set limits for the number of take-aways and other food outlets in a given area. Directives should specify the distance from schools and the maximum number that can be located in certain areas' Achieving this is likely to involve mapping existing fast food provision.

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British Heart Foundation		Page 30, recommendation 10	It is unclear how transparency of lobbying from the food and drink industry will directly contribute to the prevention of CVD. To preserve the integrity of lobbying activities from the voluntary sector, this recommendation should demand a similar level of transparency from the NGO sector. In their recent response to the Public Administration Select Committee's report on Lobbying: Access and influence in Whitehall, the Westminster Government confirmed that as of October 2009 information about ministerial meetings with outside interest groups will be published online on a quarterly basis.	Thank you. This is now recommendation 5. The aim of this recommendation is to ensure dealings between government, government agencies and the commercial sector are conducted in a transparent manner that supports public health objectives and is in line with best practice.

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British Heart Foundation		Page 31, recommendation 11	The BHF has long called for more consistency in advertising of HFSS foods between broadcast and non broadcast media and welcomes the inclusion of proposals in this area in the consultation document. We published a report, *Protecting children from unhealthy food marketing*, which outlined a proposal for a statutory system to regulate non-broadcast food marketing to children and may therefore be helpful to the development of this guidance. A copy of this report is included with this submission. It is important that restrictions on advertising of HFSS foods seek to specifically protect children from unhealthy food marketing. The BHF therefore believes that a ban on HFSS foods before the 9pm watershed would be the most effective way to ensure that children and young people are protected. As we noted in our report, *How Parents Are Being Misled: A campaign report on children's food marketing*, this would also help to ensure that parents can be confident about which food is appropriate for a child's healthy diet. A copy of the report is included with this submission. Cont…	Thank you. Recommendation 4 now includes a restriction on the scheduling of advertising of HFSS food before 9 pm and extension of regulation to include non-broadcast marketing.

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British Heart Foundation		Page 31, recommendation 11	It is also vital that we have a consistent framework for marketing of HFSS foods. For example, anomalies in the current framework allow claims that are outlawed on television to continue to be made on food packaging. We believe that NICE should include recommendations around this issue in the final guidance. It is unclear whether this recommendation is proposing voluntary or mandatory action and who would be tasked with creating the principles proposed. As the Department of Health is currently developing a set of voluntary principles for non broadcast marketing to children, it may be useful for NICE to consider how to ensure that these are successful and what the criteria for introducing a mandatory system would be.	Thank you. This is now recommendation 4. This now says 'develop equivalent standards, supported by legislation, to restrict the marketing, advertising and promotion of food and drink high in fat, salt or sugar via all non-broadcast media. This includes manufacturers' websites, use of the internet generally mobile phones and other new technologies'
British Heart Foundation		Page 33, recommendation 15	As noted above, the proposals relating to public sector food provision should include the food on offer in leisure venues.	Thank you. As noted above, recommendation 19 addresses settings where public money is spent.
British Heart Foundation		Page 34, recommendation 16	The BHF commends the inclusion of local authorities as actors in ensuring that healthy food and drinks are available in entertainment and recreation venues. This should be extended to private sector providers as a matter of good practice, as recommended in our recent report, *A Fit Choice? A campaign report on the provision of children's food in leisure venues*.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Heart Foundation		Page 35, recommendation 18	It would be useful for this recommendation to include school travel plans as well as workplace action plans. The BHF is part of the Take Action on Active Travel coalition, an alliance of transport and public health organisations committed to creating an environment that promotes active travel. Key calls from the coalition include committing 10% of transport budgets to walking and cycling and making 20mph the normal speed limit for residential streets.	Thank you. This recommendation now makes reference to the importance of ensuring that physical activity in children and young people is addressed. It refers to the NICE guidance on this topic, which includes recommendation on school travel plans
British Heart Foundation		Page 35, recommendations 19 – 24	The BHF commends the recommendations addressing the need for regional CVD prevention. We have recently embarked on an initiative to BHF resources in local areas of high cardiovascular need. The three-year Hearty Lives programme aims to reduce the high levels of CVD in particular geographical areas. We are investing funding and 'in-kind' resources and will work in partnership with local health bodies, local authorities and community organisations to provide targeted services to meet the needs of the local community. The programme aims to improve the uptake of health services in these and boost the heart health capacity of local organisations by concentrating BHF resources in these areas and has an overall budget of £9million. Following a funding round, the London Borough of Newham, Hull, Tayside and Dundee have all been selected as major areas for Hearty Lives investment. We are also funding a number of smaller projects throughout the UK. The learning from this programme may be useful to local and regional practitioners implementing these recommendations.	Thank you. The evaluation of these activities may be useful in updating the guidance in the future.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Hypertension Society		General	It is encouraging that the Guidelines focus largely on mandatory, legislative and regulatory interventions. The BHS is pleased to see that the role of high salt intake, through its effect on blood pressure, is now regarded as an avoidable cause of cardiovascular disease, and that a concerted public health approach is considered to reduce the risk in the population. The BHS also endorses the approach to promoting physical activity and to avoiding the use of trans-fats. In general, this is an excellent document with a couple of important omissions: 1 There is insufficient emphasis on the need to reduce the consumption of food and particularly drinks containing large quantities of refined sugars and high in calories. 2 The links between high intake of refined sugars and a high calorie diet with obesity and type 2 diabetes and the inevitable increased risk of CVD are underemphasised A succinct summary would be very useful as most people will not read the whole document. Nevertheless, a major step forward.	Thank you. The role of obesity is referenced in the guidance, as is the relevant NICE guideline. Please note that NICE is currently developing guidance on prevention of diabetes and on a 'whole systems approach to preventing obesity (please see http://guidance.nice.org.uk/PHG/InDevelopment?textonly=false) A quick reference guide to the guidance will be produced.
British Hypertension Society		Recommendation 3	We have already seen significant activities aimed at a reduction in the salt content of processed foods and in the manufacturing of food items. The document acknowledges the progress has been slow. It would be useful to set a timeline to the voluntary approach towards national targets after which mandatory regulations would follow.	The guidance suggests a goal of a maximum intake of 6g per day for adults by 2015 and 3g by 2025

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Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Hypertension Society		General	While the seminal contribution of Geoffrey Rose to population – preventive strategies is acknowledged, his concern about the "prevention paradox" should not be ignored. People are willing to accept recommended changes to lifestyle without obvious short-term personal benefits.	Thank you. The difficulty of achieving individual behaviour change without population level initiatives is part of the rationale for the approach adopted
British Hypertension Society		Recommendations 21 and 22	The point above is particularly relevant for these sections. The targeted "deprived" population is likely to be refractory to well-meaning advice. Public health doctors, who provide most of the evidence, often appear to be detached from "real life".	Thank you. We acknowledge the problems experienced by many disadvantaged communities. The guidance aims to address these by making population level recommendation.
British Hypertension Society, Imperial College London		General	Major omission is lack of reference to risks of obesity, type 2 diabetes and consequent 2-4 fold increase in risks of CVD associated with consumption of high refined sugar containing foods(cereals) and drinks.	Thank you. The final guidance acknowledges the significance of obesity and diabetes. Please note that NICE is currently developing guidance on prevention of diabetes and on a 'whole systems approach to preventing obesity (please see http://guidance.nice.org.uk/PHG/InDevelopment?textonly=false)
British Hypertension Society, Imperial College London		General	A concise summary is necessary.	A quick reference guide to the guidance will be produced
British Hypertension Society, Imperial College London		Page 23	Important omission Department of Education	Thank you. The draft guidance referred to the Department for Children, Schools and Families. This has been altered to 'Department for Education'.

PUBLIC HEALTH PROGRAMME GUIDANCE – CARDIOVASCULAR DISEASE

Consultation on the Draft Guidance – Stakeholder Response Table

Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Retail Consortium (BRC)		General	Thank you for giving us the opportunity to comment on the NICE draft guidance on the prevention of cardiovascular disease at population level. BRC and several of its members participated and provided comments at the workshops organised to discuss the guidance; however we felt it was important to reiterate some of our fundamental concerns. While we understand that NICE has developed the guidance in response to a request by the Department of Health, it remains unclear the role that the guidance is to play.	Thank you.

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Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Retail Consortium (BRC)		General	Cardiovascular disease is multifactorial; it is well documented that smoking, obesity, living a sedentary life, gender, stress, etc. are all risk factors. The Department of Health has developed strategies and campaigns that aim to reduce the impact of some of these risk factors. Examples are: Healthy Weight Healthy Lives, published in 2008, which is a comprehensive cross Government Department strategy aimed at supporting people maintaining a healthy weight, this strategy covers all the reformulation work led by FSA and done by industry; Change4life, a very visual campaign that 'is here to help families eat well, move more and live longer happier lives' and the policy decision to ban smoking in public places. We strongly believe that the process of developing the current document should be put on hold and thought should be given to what would be a useful document that would complement or fill in the gaps in all the existing strategies and policies, as opposed to going over the same ground, which is what the document is doing at the moment. For this reason we will not provide specific comments on the recommendations.	Thank you. This guidance has been produced following referral of the topic by the Department of Health. The intention of the PDG is that it should support and add to the work already underway in other settings. The guidance is aimed at providing support for population level policy changes to reduce the substantial burden of cardiovascular disease, and also to support professionals in working to reduce the burden of disease.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Retail Consortium (BRC)		General	In order to develop such a document, if it was felt there was a need for one, NICE must be fully aware of the detail of all existing strategies, campaigns and policies as well as of all the work and the progress made by industry. Coordination and engagement with the right Government Departments and relevant stakeholders from an early stage is crucial to the success of the project. One of the issues that concerned us greatly and which should be addressed in any future work is the apparent lack of methodology used to establish the use of evidence. A systematic review of all the existing evidence must be the methodology used and for the sake of transparency, information on all the evidence considered should be made available. The detail in some of the recommendations in the draft guidance does not reflect current policy and it is not possible to understand from the document (not even from the more extensive background paper) whether this is because of new available evidence. Cont…	Thank you. The PDG is aware of work in relevant areas and the final guidance makes more reference to the welcome progress made to date. The PDG considered reviews of evidence and expert testimony in developing the guidance. In addition, relevant reviews of evidence from other NICE guidance and guidelines was brought before the committee. These sources were used as the basis for developing the recommendation. They are listed in the guidance and were put out for public consultation as part of the process..
British Retail Consortium (BRC)		General	A good example is the 14% saturated fat consumption figure, when the Government is currently using a figure of 13.3% and the suggested recommended figure of 7% when the Food Standards Agency and the Department of Health is recommending 11%, or the 0.5% recommended figure for trans fats; it is unclear where these figures come from.	Thank you. As indicated, the 7% figure comes from Japan.

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Cambridge Health and Weight Plan		General	Thank you for the opportunity to comment on the guidance. We very much welcome the initiative to produce such guidance at population level.	Thank you.
Cambridge Health and Weight Plan		General	Cambridge Health and Weight Plan (CHWP) offers a range of weight management options, including Low Calorie Diets (LCDs) and Very Low Calorie Diets (VLCDs) for those who are overweight and clinically obese. We would be more than happy to forward to you the relevant scientific research that supports our weight management programme.	Thank you. LCDs and VLCDs are not within the remit of this guidance as the guidance is aimed at producing population level recommendations.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Cambridge Health and Weight Plan		Rec 2-legislation on the FSA's Integrated Label	Following your draft recommendation to establish legislation that would implement the FSA's Integrated Label, we would like to comment that such labelling is not appropriate for all foods. In the case of LCDs and VLCDs the application of the Integrated Label is more likely to be misleading and cause confusion, rather than be informative. The reason for this is that our products have been carefully designed to provide between 415 kcal and 1500kcal/day in three or four portions per day, containing all the necessary daily nutrients (with addition of a healthy meal at the higher energy intake levels). Their specific product composition means that these formula foods have a high nutrient and low energy content compared to normal foods. When consumed as directed the total salt intake per day will be lower than the GDA of 6g/day, yet they may be labelled as high in salt. This would mean that an amber declaration would have to be shown because of the salt (and sugar) content even though the total daily intake of those food components will be significantly lower than the GDA. We would like to ask you to consider this when making your recommendation, as the use of the FSA's Integrated Label is not always appropriate.	Thank you. This is now recommendation 6. This guidance is aimed at developing population level recommendations. People requiring LCD and VLCD will require advice and support from an appropriate professional.
Cambridge Health and Weight Plan		Rec 2-legislation on the FSA's Integrated Label	We are surprised to see that NICE is provisionally recommending the development of legislation to implement the FSA's Integrated Label, as this is currently still a voluntary system.	Thank you. The PDG feel that a single front of pack (FOP) traffic light colour coded system is necessary to provide clarity, and that legislation for its universal implementation should be considered.

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Wednesday 14th October – 16th November

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Cambridge Health and Weight Plan		Rec 2: restrict advertising for products falling in the amber and red category	This action would need to take into account any future exemptions to the future FSA Integrated Label.	Noted.
Cambridge Health and Weight Plan		Rec 21: Programme development	The draft Guidance suggests that a number of NICE recommendations need to be taken into account when developing CVD programmes. We feel this section should include reference to the obesity guidance as that contains a number of useful recommendations, amongst other dietary management, that should be taken into account when developing CVD programmes.	Thank you. The NICE obesity guideline has been added to this section.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Consensus Action on Salt and Health (CASH)		General	The maximum recommended intake target for salt of 6g a day was chosen by COMA(1) and SACN(2) as an achievable target for the food industry, rather than as a health-related target. Since 2003 our salt intake has reduced from 9.5 to 8.6 g/day by May 2008 (3). It will have fallen further and continue to fall as the food industry makes progressive reductions in the amount of salt added to foods. We feel it is now time to revise the salt target based on the evidence for the maximum benefits that could be achieved in terms of reducing strokes, heart attacks and heart failure which remain the leading the cause of death in the UK. The UK is leading the world in reducing salt intake by getting the food industry voluntarily to reduce the very large and unnecessary amounts of salt added to foods. It will therefore be relatively easy to reduce salt intake below the current arbitrarily chosen of 6 g/day.	Thank you. The final guidance sets out a goal of a maximum of 6g per day for adults by 2015 and 3g by 2025.

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Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Consensus Action on Salt and Health (CASH)		General	The WHO over seven years ago set a worldwide target of 5g a day for all adults (4). Evidence published since then suggests that the target should be lower. The UK should, at the very least, lower its recommended target based on the strong scientific evidence to 4g/day or less. We feel that the 6 g/day target will be reached around 2012 and the 4 g/day could be reached by 2017. In fact the Reference Nutrient Intake (RNI) for sodium for adults was set at 1600 mg/day (5). This is equivalent to 4g of salt. The rationale for setting such a high target of 6 g/day in the UK was to give an initial target that the food industry felt that it could be achieved. This was to engage them and make the voluntary reductions of salt added to foods.	Noted.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Consensus Action on Salt and Health (CASH)		General	There was no other clear rationale for setting such a high target of 6g/day, as the bigger the reduction in salt intake, the bigger the benefit. Indeed there is clear evidence that the benefit goes down to 3g salt a day (6). The INTERSALT study demonstrated that, in communities with a salt intake of less than 3 g/day, there was no rise in blood pressure with age (7). Randomised trials have shown that, within the range of 12 to 3 g/day, the lower the salt intake achieved, the lower the blood pressure (8,9,10). As raised blood pressure is the major cause of cardiovascular disease, a reduction in salt intake would therefore reduce cardiovascular risk. For every gram reduction of salt in the UK diet, approximately 13,000 strokes and heart attacks would be prevented, half of which would be fatal (8) Based on the evidence the daily intake should be reduced to 4g or less for adults and much lower for children.	Noted. The final guidance sets a goal of 3g by 2025.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Consensus Action on Salt and Health (CASH)			References 1. Report of the Cardiovascular Review Group Committee on Medical Aspects of Food Policy. Nutritional Aspects of Cardiovascular Disease. 1994. London: HMSO. 2. Scientific Advisory Committee on Nutrition, Salt and health. 2003. The Stationery Office. Available at http://www.sacn.gov.uk/pdfs/sacn_salt_final.pdf. 3. Food Standards Agency. Dietary sodium levels surveys. Tuesday 22 July 2008. Available at: http://www.food.gov.uk/science/dietarysurveys/urinary. 4. Joint WHO/FAO expert consultation on diet, nutrition and the prevention of chronic diseases. 2002. Geneva. Available at http://www.who.int/hpr/NPH/docs/who_fao_experts_report.pdf. **5.** Department of Health (1991), "Dietary Reference values for food, energy and nutrients for the United Kingdom", HMSO, London.	Thank you for these references.

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Consensus Action on Salt and Health (CASH)			6. He FJ, MacGregor GA: A comprehensive review on salt and health and current experience of worldwide salt reduction programmes. J Hum Hypertens 2009;23:363-384. 7) Intersalt Cooperative Research Group. Intersalt: an international study of electrolyte excretion and blood pressure. Results for 24 hour urinary sodium and potassium excretion. BMJ 1988;297:319-328. 8) He FJ, MacGregor GA: How far should salt intake be reduced? Hypertension 42:1093-1099, 2003. 9) MacGregor GA, Markandu ND, Sagnella GA, et al: Double-blind study of three sodium intakes and long-term effects of sodium restriction in essential hypertension. Lancet 1989;2:1244-1247. 10) Sacks FM, Svetkey LP, Vollmer WM, et al: Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. N Engl J Med 2001;344:3-10.	Thank you for these references.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		General	In our opinion, the document is comprehensive, and its aim to provide guidelines on the prevention of cardiovascular disease (CVD) at a population level fits well with our policies. However, we believe that one specific issue needs to be clarified, that is, the document should distinguish between the different UK Governments because, as a devolved responsibility, they all have different strategies for CVD to reflect different national profiles. Despite this, the data on CVD deaths on page 4 appears to refer to the UK as a whole. The list under 'Government policy' on page 7 appears to reflect only those policies pertinent to England, and paragraph 3.7 appears to refer simply to 'national policy', though not to which nation it refers. We feel that such mixing of UK and national information and perspectives can be potentially confusing.	Thank you. The figures used in the final guidance have been altered to be those for England.
Department Of Health		General	Some of the recommendations look very helpful to CVD prevention programmes at local level, including healthy eating programmes, and these are to be welcomed. However, other recommendations appear to be at odds with Government policy and/or pose serious questions about implementability, particularly in a context of severe fiscal restraint. Examples include NICE's recommended ban on trans fats, recommended changes to levels of saturated fat intake, and recommended changes to VAT.	Thank you. The policy level recommendation (1-12) set out actions which could be taken to reduce the population level burden of CVD. The final guidance notes that the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through the normal political processes.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		General	The guidance covers salt, trans fats, saturated and polyunsaturated fats, and a healthy diet. It does not appear to address population level interventions on tobacco, obesity, lack of physical activity or high alcohol consumption as CVD risk factors. We note that these are addressed by your complementary guidance, either published or in development. It would be helpful if you could clarify more explicitly whether these have not been included because of the development of other guidance. There is also a large body of research evidence that shows that opportunistic case finding and the delivery of simple advice for alcohol misuse are effective interventions directed at people drinking at increased and high-risk levels who are not typically complaining about or seeking help for an alcohol problem. The research evidence includes at least 56 controlled trials (Moyer *et al*., 2002). A recent Cochrane Collaboration review (Kaner *et al*., 2007) provides substantial evidence for the effectiveness of alcohol case identification and the delivery of brief advice. For every eight people who receive simple alcohol advice, one will reduce their drinking to within low-risk levels (Moyer *et al*., 2002). This compares favourably with smoking where only one in twenty will act on the advice given (Silagy & Stead, 2003). This improves to one in ten with nicotine replacement therapy.	The guidance contains recommendation on physical activity. Tobacco, alcohol and obesity are covered by other NICE guidance. Links to other NICE guidance documents are made within this document.

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Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		General	The draft guidance is unlike previous Public Health guidance produced by NICE, and has gone into areas that lie beyond NICE's established remit, for example fiscal policies and EU legislation. We feel that it may be challenged by some stakeholders on that basis.	We agree that this guidance goes beyond what some other guidance documents have considered. However, the recommendations are still within the remit of NICE's Statutory Instrument as revised in 2005. The recommendations provide the outline for a sound and evidence based national framework for action to prevent CVD at population level. As noted earlier, the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through the normal political processes
Department Of Health		General	Could you please consider distinguishing more clearly the discussion of England-only policies, and the different UK Governments and devolved responsibilities for health, and particularly Public Health. In England, it would be helpful for the guidance to recognise the relationship that we have with the Food Standards Agency.	Thank you. The section 'government policy' is intended to be a rapid list of some of the relevant government documents. It is not possible in the limited space available to provide a more detailed discussion.
Department Of Health		General	Some of the recommendations appear to conflict with the current advice of bodies that have the role of advising Government in these areas (in particular, the Scientific Advisory Committee on Nutrition), and it is not clear how the work of such bodies has been taken into account. Could you please clarify this.	The PDG is aware of the current advice. However, in some areas, for instance with regard to IPTFAs, the view of the committee was that the evidence suggested that additional benefits could be gained from taking a different position.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		General	Many of the draft recommendations raise some issues that have been debated widely in Government, and have not been progressed because of difficulties in implementing them. It is not clear how issues of implementability (including implementation costs) have featured in the formulation of the guidance, and we would appreciate clarification.	Thank you. One of the purposes of consultation and fieldwork (carried out on all NICE public health guidance) is to address issues of implementability beyond that available from the evidence, knowledge of the PDG and experts consulted. The final guidance notes that 'the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes'
Department Of Health		General	Some recommendations appear to be based on an incomplete understanding of the existing policy and legislative framework.	Thank you. The PDG believe the final guidance reflects their thorough understanding of policy and legislative frameworks.
Department Of Health		General	In terms of wider impact on Local Authorities (LAs), there is much across the recommendations that might put pressure on their resources. If this were Government policy development, a new burdens assessment would be undertaken to establish whether there were any additional net burdens on LAs. If this were the case, then a commitment from Government that the cost of these burdens to LAs would be met would be necessary. In this light, and in the context of severe financial restraint, we believe that it may be better if the guidance were less directive, and more suggestive in what LAs could do to make things work better.	Thank you. A costings tool will be published with the final guidance to enable estimates of costs and savings to be made locally. Many of the recommendations represent current 'good practice'.

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Department Of Health		Section 1 Page 4	On 'Key Priorities', could you please consider differentiating between first order priorities that are feasible (and will add value to CVD prevention programmes at local level), and second order priorities that will be difficult to progress, and would need to be taken forward over the medium to longer-term. These would include those recommendations that run counter to Government policy and/or would demand significant additional resources for implementation.	Thank you. The PDG felt that it was not possible to provide a comprehensive ordering of priorities as this will vary with the perspective of the actors involved.
Department Of Health		Page 5	In our view, the reference to spearhead areas needs to make it clear that they are in England only. The relevance of citing the CVD Coalition's destination 2020 here is not obvious; given that the section is about what CVD is, and its prevalence/incidence.	Thank you. NICE guidance is for England only.
Department Of Health		Page 7	The *Coronary Heart Disease National Service Framework* (2000) which set the scene originally, with a whole section on prevention, appears to have been omitted altogether from the list of English policies on CVD. The NSFs on diabetes and renal services also appear to be absent from the list, despite the emphasis on prevention in both.	Thank you. The list in the guidance is not intended to be a comprehensive list of policies. As indicated, it lists a number of the policy papers published since the 'Choosing health' white paper.
Department Of Health		Section 2, Public Health Need and Practice (Page 8)	Could you please consider inserting a reference to the most recent inequalities policy document - *Health Inequalities: Progress and Next Steps* - in the list of policy documents to help prevent CVD.	Thank you. This has been added.

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Department Of Health		Page 10, paragraph 3.5	May we suggest you refer to the programme as the 'NHS Health Checks programme' throughout the guidance to avoid confusion. We feel that there is no need to refer to 'Putting Prevention First' if NHS Health Checks is mentioned, as it is already well known. • The NHS Health Checks programme is based on existing NICE guidance, and is proven to be clinically and cost-effective. Therefore, stating that the NICE guidance complements the NHS Health Check programme would appear to be misleading. • The NHS Health Check programme is a universal and systematic programme for people between the ages of 40 and74 who do not have an existing vascular disease. We are aware that this draft guidance is on prevention of cardiovascular disease, but we feel that there may be some confusion as the NHS Health Checks programme covers vascular disease, and is thus focusing on risk factors for coronary heart disease, stroke, diabetes and chronic kidney disease. Cont…	Thank you. NHS Health Checks are mentiond in recommendation 15. However, the PDG were keen to develop recommendations for upstream prevention

Consultation on the Draft Guidance – Stakeholder Response Table

Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Page 10, paragraph 3.5	• In our view, it is misleading to claim that either the NHS Health Checks Programme or this new piece of NICE guidance will substantially reduce the numbers of people who need statin or anti hypertensive medication. In fact our modelling has shown that, in the short term, the numbers of people prescribed statins and anti hypertensives will go up, as more people are found to need them. The numbers of people prescribed these drugs will go down in the long term, but this will only happen when the benefits of the intervention side of the programme (i.e. referrals to stop smoking and weight management services) are noticeable. We would suggest changing section 3.5 to read: "The NHS Health Check programme will assess the risk of heart disease, stroke, kidney disease and diabetes among people aged 40-74, and will support them to reduce or manage that risk through individually tailored advice. The programme is based on existing NICE Guidance, and is proven to be clinically and cost effective. This new NICE guidance complements the NHS Health Checks programme by focusing on reducing the risks for an entire population. This will benefit the NHS, local authorities and industry, as well as individuals, and will also enable services to focus on those who need treatment".	While improving case finding may well increase the need for prescriptions of various sorts. Reducing the incidence of CVD and risk factors by primary prevention, through actions such as those included in the guidance or those associated with NHS Health Checks may reduce the need for treatment. Thank you. This guidance focuses on population level recommendations. The PDG feel that NHS Health checks represent an individual-based approach, which may be complementary to the current guidance. The guidance provides a weblink to the NHS Health checks programme.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Pages 11 – 12, Paragraph 3.9	'*In the past in the UK, interventions focused on individuals have tended to dominate CVD prevention activities'*. As noted above, not only does the CHD NSF (England) set a framework for population level prevention, but also the smoking ban, price and sales control of tobacco are excellent examples of population measures, which have all taken place in the past.	Thank you. The guidance acknowledges the importance of population measures to address tobacco use, however these are not the focus of the guidance.
Department Of Health		Pages 11 – 12, paragraph 3.9	We feel that this is an ideal opportunity to mention the NHS Health Checks programme, as it is a prime example of an upstream intervention. Could you please consider adding a sentence saying: 'The NHS Health Checks programme is a good example of this. These checks will assess people's risk to heart disease, stroke, kidney disease and diabetes and be based on straightforward questions and measurements such as age, sex, family history, height, weight and blood pressure. They would also include a simple blood test to measure cholesterol".	Thank you. The PDG were keen to make recommendations about upstream prevention. Recommendation 15, which refers to NHS Health Checks, includes a hyperlink to information about the programme.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Page 13, paragraph 3.12	You may wish to be aware that the NHS Health Check programme is attempting to address the significant differences in life expectancy due to vascular disease between spearhead areas and the rest of England. We feel that there needs to be some explanation here of how the NHS Health Checks programme is designed to reduce health inequalities. Could you please consider extending this paragraph to include the following text: "The NHS Health Check programme has been designed to help reduce health inequalities between spearhead areas and the rest of England. The basic risk assessment and management components of the check are suitable to be undertaken in a variety of settings including pharmacies, community centres and other sites such as supermarkets and football grounds, as well as GP practices. This means that people who are not in touch regularly with formal health care, particularly GP services, will be encouraged to access the checks at convenient locations and times."	Thank you. While NHS Health Checks are an important programme it is not possible to go into them in detail in this guidance
Department Of Health		Page 14, paragraph 3.14	This refers to 'stretched' targets; these are actually '*stretch*' targets. On a factual point, 51 out of the 150 Local Strategic Partnerships have already selected NI 121 (mortality rate from all circulatory diseases at ages under 75) as an indicator for this round of LAAs (which runs to 2011). The text may currently suggest that this would be a new approach rather than something that is already a focus for many.	Thank you. This has been corrected.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Page 15	It would be helpful if the section on single risk factors could include evidence of why high alcohol intake has been included, in the same way it has for other risk factors such as smoking & diet.	Thank you. The guidance makes reference to the recent NICE guidance on alcohol.
Department Of Health		Pages 15 – 16, paragraphs 3.19 and 3.20	The NHS Health Check programme does not deal with alcohol as a risk factor for vascular disease, as evidence suggests that alcohol is a vaso dilator, whilst the other risk factors are vaso constrictors and thus have different effects on the body. High blood pressure is not listed as a key CVD risk factor here. It could be argued that whilst high alcohol consumption can lead to high blood pressure (a risk factor for CVD) and causes other health problems; it is not directly linked to CVD. 3.20 We feel that it could be beneficial to briefly mention the smoking intervention side of the NHS Health Checks programme here. An extra sentence could possibly read: “All smokers who attend an NHS Health Check consultation will be assisted to join a smoking cessation service”.	Thank you.

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Department Of Health		Pages 17 – 18, paragraphs 3.27 and 3.28	We are a little unsure about the numbers quoted here and the economic modelling they are based on. The numbers used here seem particularly high. 3.28 It could be helpful here to include an extra sentence that shows that the NHS Health Check does include a physical activity intervention.. A possible sentence could read: "All people attending an NHS Health Check who are failing to do enough exercise will be encouraged to do more, and helped to find out about options in their area".	These figures (now para 3.21) are taken from the economic modelling carried out for the programme Thank you. Recommendation 15 includes a link to the NHS Health Checks programme website.
Department Of Health		Pages 21 – 22	May we suggest some reference to the NHS Health Check in this paragraph as a good example of a population approach.	Thank you. The PDG feels that the NHS Health Check programme is a good example of a screening approach not a primary prevention population approach.
Department Of Health		Page 23	Further clarification of which Government 'has addressed – and continues to address' may possibly be needed. Linked to this, in the section '*Who should take action*' , it would be helpful if the remit of each individual or organisation could be clarified. For example, the Chief Medical Officer and the National Clinical Director for Heart Disease and Stroke (please note correction of title) and the Department of Health are only responsible for policy in England.	Thank you. NICE guidance is produced for England, although it is of interest to other countries.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 3, Recommendations (General) (Page 23)	We suggest that you might wish to clarify whether the title "Chief Scientist" is used to refer to the Government Chief Scientific Adviser, the DH Chief Scientific Adviser, the DH Chief Scientist – or to similar official positions in the other UK countries.	Thank you. This has been clarified in the guidance

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 - Rec 1: common agricultural policy (Page 24)	We would suggest amending Recommendation 1 to read: "The common agricultural policy (CAP) is the overarching framework used by European Union member countries to form their own agricultural policies. However it introduces a number of significant distortions, including on certain food prices in the EU which can push food prices up, negatively impacting consumers, particularly those on lower incomes. Ongoing reform of the CAP should remove such distortions, connect farmers more fully to market and consumer demand therefore providing an opportunity to indirectly assist government action on preventing CVD in the UK. The evidence suggests that among the measures that could be considered are:" We would also suggest that the CAP is an EU wide policy so should be looking to prevent CVD in the EU, not just the UK.	Thank you. This recommendation (now number 8) has been amended to say 'The common agricultural policy (CAP) is the overarching framework used by EU member countries to form their own agricultural policies. The burden of diet-related disease has grown considerably since CAP was first implemented. CAP reform offers a significant opportunity to address the burden of CVD. However, there are still a number of significant 'distortions' in relation to certain food prices and production processes which potentially increase the burden of disease. Further reform should aim to remove these distortions to promote health and wellbeing and to provide a basis for UK government action to prevent CVD . The CAP has two main 'pillars': market measures (first pillar) and rural development policy (second pillar). Recent CAP reform has shifted money from the first to the second pillar which now focuses more on 'public goods'. However, health has not been formally recognised as a 'public good'. CAP reforms have begun to address this issue, but a clearer focus on CVD and its antecedents (that is, the production of foods high in fats, sugar or salt) is needed.' The guidance is aimed at addressing CVD in England, so although these changes may support reduction of CVD at EU level this is not the aim of the guidance.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 - Rec 1: common agricultural policy (Page 24)	Under the heading 'What action could be taken?' we suggest amending the first bullet point to read: "Negotiate to amend the Common Agricultural Policy (CAP) to ensure the process of EU reform helps increase awareness of public health issues. Specifically, a more market oriented CAP could see farmers' production decisions being influenced by the increased demand from consumers for healthy produce as recommended in healthy eating guidelines, such as the 'eatwell plate'."	Thank you. This is now recommendation 8. The first bullet has been amended to say 'negotiate at EU and national level to ensure the CAP takes account of public health issues. Health benefits should be an explicit, legitimate outcome of CAP spending. This can be achieved through formal recognition of health as a 'public good'.'
Department Of Health		Section 4, Rec 1: common agricultural policy (Page 25)	The following comment relates to the two bullet points at the top of page 25: In our view it is not possible for the CAP which is an EU wide policy to enforce such domestic level fiscal incentives. Therefore we would suggest moving these recommendations to what we would see as a more appropriate section of the guidance such as recommendations 4 and 5 which deal with fats.	Thank you. These bullet points have been moved to recommendation 2 and amended.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 – Rec 2: product labelling and marketing (page 25)	The FSA recently consulted on the practical issues that need to be resolved for an integrated front of pack (FOP) nutrition labelling approach to work in real life settings and help consumers to make healthier choices. The independent evaluation study on FOP nutrition labelling found that a single scheme would be helpful for consumers and that an integrated FOP labelling approach providing 'high/medium/low' text, traffic light colour coding and %GDA information was most effective in terms of consumer comprehension, consumer preference and enabling consumers to assess the healthiness of a product. The consultation sought views on practical issues that need to be resolved for an integrated FOP nutrition labelling approach to work in real life settings and help consumers to make healthier choices. The consultation also sought views on the related costs and benefits as identified in the draft Impact Assessment. The UK is negotiating to maintain European Member States' flexibility to operate national schemes which meet their consumers' needs. Cont…	Thank you. Thank you. The PDG agree that it is important that the flexibility is maintained (recommendation 6)

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 – Rec 2: product labelling and marketing (page 25)	We would suggest that any proposals to restrict advertising for products that fall into the amber and red categories of the FSA's FOP labelling system should be proportionate in its use. Not all food products carry traffic light labelling and those that do often have one red or amber traffic light even if all others are green. This recommendation therefore carries the risk that no food products would be able to be advertised. For the purposes of TV, programming measures are already in place to prevent the advertising of all foods high in fat salt and sugar (HFSS) in and around children's programming.	Recommendations on restricting advertising are now included in recommendation 4. This recommends restricting advertising HFSS up to 9.00pm on TV, and to develop standards for non-broadcast media.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 - Rec 3: salt (page 25)	Since 2003, the FSA has had in place a programme of work to help UK consumers reduce their salt intakes. In 2003, the Scientific Advisory Committee on Nutrition (SACN) published its report, 'Salt and Health'. SACN concluded that the evidence of a link between high salt intake and high blood pressure was stronger than it had been when the issue was last considered in the early 1990s. SACN also concluded that a reduction in the average salt intake of the population would proportionally lower population blood pressure levels and confer significant public health benefits by reducing the risk of cardiovascular disease. SACN recommended that the average salt intake of the population should be reduced from the then current levels of 9.5g to 6g per day, with lower levels recommended for children. Following publication of the SACN report, the FSA and DH made a commitment to work towards reducing salt intakes in line with the report's recommendations. The programme of work to achieve that goal has three main strands: • a public campaign to raise consumers' awareness of why a high salt intake is bad for their health and what they can do to reduce intakes;	Thank you. The PDG is aware of the work of SACN and the FSA to reduce salt intake, and acknowledge the beneficial impact of this work to date but felt that it was important to accelerate this reduction. Recommendation 1 says 'Over recent years the food industry, working with the Food Standards Agency, has made considerable progress in reducing salt in everyday foods. As a result, products with no added salt are now increasingly available. However, it is taking too long to reduce average salt intake among the population.'

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Department Of Health		Section 4 - Rec 3: salt (page 25)	• working with the food industry to reduce levels of salt in foods as around 75% of the salt we eat is already in the every day foods that we buy; and • front-of-pack labelling to provide additional information to consumers on the levels of salt (and other nutrients) in food.	See comments above
Department Of Health		Section 4 - Rec 4: saturated fats (page 26)	The Government's recommendation is that saturated fat intake should be no more than 11% total energy. The recommendation in this report therefore goes beyond current practice. In February 2008, the FSA published its saturated fat and energy intake programme, which outlines the actions needed to help consumers reduce saturated fat intakes and balance the amount of calories they consume with their needs by: • improving consumer awareness and understanding of healthy eating with particular focus on the impact of saturated fat on health; • encouraging greater promotion of, and increased uptake of healthier options, eg reduced fat products and manufacturers' and retailers' 'healthier' ranges; • encouraging increased accessibility of smaller food portion sizes; and • encouraging voluntary reformulation of mainstream products to reduce saturated fat and energy.	Thank you. The PDG believe that there are additional benefits to be had from reducing saturated fat intake further.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 - Rec 4: saturated fats (page 26)	In 2009, the FSA has launched a consumer awareness campaign and two consultations of recommendations targeted at the food industry. The consultations focus on foods which are significant sources of intake of saturated fat, or energy (from sugar) namely : biscuits, cakes, confectionery, pastries, sugar containing soft drinks, dairy and meat products, and savoury snacks.	Thank you.
Department Of Health		Section 4 - Rec 5: trans fats (page 27)	In 2007, the FSA carried out a review of trans fats at the request of the Secretary of State for Health. This review looked at the health impacts of current intakes of trans fats, recent voluntary activities by the UK food industry to reduce levels of artificial trans fats in food, and the legislative actions already taken in some countries. As part of the review, the Agency sought the advice of SACN. SACN advised that while there is consistent evidence to support a moderate impact of dietary trans fats on increasing risk of coronary heart disease, the evidence for an association between trans fats and cancer, obesity and diabetes is limited and contradictory. SACN recommended that average intakes of trans fats should not exceed a maximum of 2% of food energy.	Thank you. The PDG are aware of the work of SACN and the FSA on trans fats. Recommendation 3 says 'In recent years many manufacturers and caterers, with the encouragement of the Food Standards Agency and other organisations, have considerably reduced the amount of IPTFAs in their products. However, certain sections of the population may be consuming a substantially higher amount of IPTFAs than average'. The guidance makes a number of recommendations to ensure all groups are adequately protected from trans fats, These are supported by a number of successful examples across Europe and elsewhere.

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Department Of Health		Section 4 - Rec 5: trans fats (page 27)	The FSA's Board considered the findings of this review and noted that voluntary measures taken by the UK food industry to reduce levels of trans fats in foods had been successful in reducing consumers' dietary intakes to low levels of 1% of food energy (half the maximum recommended average intake). The Board unanimously agreed that, because of the industry's action, mandatory restrictions on trans fats were unnecessary and that progress to reduce saturated fat levels in foods should be a priority to reduce premature deaths from cardiovascular disease.	Thank you. As noted, the PDG felt that as there are some groups who are likely to be at higher risk, further action to protect people from IPTFA was warrented.
Department Of Health		Section 4 - Rec 6 (page 28)	Use of the word 'ensure' in this recommendation appears inconsistent with the Healthier Food Mark policy of a voluntary scheme, and to agree with the stance taken by the Council of Food Policy Advisors (CoFPA) which advocates a mandatory scheme. The first phase pilots of the Healthier Food Mark (which include both healthier and more sustainable food) started in October, with second phase pilots in the next year, followed by an evaluation and then formal consultation before roll out.	This recommendation (now number 10) has been amended. It now says 'assess the effectiveness of the 'Healthier food mark' pilot. If successful, develop a timetable to implement it on a permanent basis'

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Department Of Health		Section 4 - Rec 6 (page 28)	As policy background, the rationale for having selected to go down the voluntary route with HFM (at least until 2011) is: The development of the Healthier Food Mark follows the publication of `*Food Matters: Towards a Strategy for the 21st Century*`, published by the Prime Ministers Strategy Unit (PMSU) in July 2008: www.cabinetoffice.gov.uk/strategy/ . `*Food Matters*` identified the need for new arrangements to ensure that Government food policy objectives are delivered in a more integrated manner. The vision and objective is to establish a voluntary Healthier Food Mark in the public sector so that public sector food reaches a standard to make a positive contribution to a nutritionally balanced diet and improves the sustainability of public sector food procurement. At worst the mark will be cost neutral, and, preferably, cost saving to both providers and purchases of public sector food (though a reduced number of simplified sets of requirements across the very large public sector market).	Thank you. As indicated above, this recommendation has been amended.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4 - Rec 6 (page 28)	The Department of Health is working, in consultation with a cross-Government working group, towards establishing the criteria (both nutrition and sustainability) for the Healthier Food Mark in Spring 2009 and piloting across the public sector later in October 2009. A full consultation process will follow the evaluation of the pilot stage in 2010, with a view to possible launch late in 2010. The Healthier Food Mark will be awarded to participating public sector organisations that achieve specified standards for their catering services. Guidance will be issued to assist participating caterers in the application of the standards. Though initially the Healthier Food Mark will be available to all public sector organisations, there is no reason why it could not in time be extended to the private sector organisations, given that many private sector commercial catering companies provide catering facilities within public sector organisations. The Healthier Food Mark is currently being piloted with up to 50 public sector organisations. The Scottish Government and Consumer Focus Scotland will continue to roll out their Healthy Living Award north of the border. SWANI colleagues are engaged on any opportunities and impacts provided by the Healthier Food Mark. In Wales, they will continue to roll out the Healthy Options Award as the approach to promoting healthier choices in catering businesses.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4, Rec 9 (page 29)	Health Impact Assessments are part of the overall policy Impact Assessment process. As such, DH has no issue with this recommendation.	Thank you.
Department Of Health		Section 4, Rec 9, Second bullet (page 29)	You may wish to reinforce the health inequalities focus by adding to final sentence – "Monitor the outcomes of policy, *including health inequalities policy,* following the assessment and use them to follow up and amend future plans."	Thank you. The PDG agree that it is important to include the potential impact on health inequalities. Recommendation 12 now addresses monitoring and the importance of monitoring dietary intake in different groups.
Department Of Health		Section 4, Rec 9: third bullet (page 29)	You may wish to reinforce the health inequalities focus by adding to final sentence - "Ensure that there is continuous progress towards a healthy level of consumption of these nutrients, *particularly in disadvantaged areas and groups*."	Thank you. Recommendation 12 now addresses the need for monitoring and reporting of dietary intake in different population groups
Department Of Health		Section 4, Rec 10 (page 30)	DH has no issue with this recommendation. You may wish to be aware that commercial interests are represented on the cross-government strategy board on food.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4, Rec 11: children (page 30)	In our view, the recommendation to ban the advertising of all HFSS foods on TV and other broadcast media including new technologies goes beyond what we feel can currently be justified. We take a proportionate approach with a mandatory ban on HFSS products during children's TV programming but not a total ban which would cover all advertising including that to adults. Restrictions on food and drink advertising in and around children's TV programming have had a significant impact on reducing children's exposure to broadcast HFSS food advertising. Ofcom will review the effects of the full HFSS restrictions in 2010. In addition, there are existing mandatory, self-regulatory rules about the content of adverts for food and soft drink to children in non-broadcast media including paid-for-space on the internet. The Government has a commitment to look to develop a set of voluntary principles to underpin all forms of marketing and promotion of food and drink to children, particularly where established mandatory self- or co-regulatory regimes do not exist.	Thank you. Recommendation 4 now aims to 'ensure children under 16 are protected from all forms of marketing, advertising and promotions (including product placements) which encourage an unhealthy diet.' It recommends extending scheduling restrictions on TV up to 9.00 pm, and the development of standards for non-broadcast media.
Department Of Health		Recommendation 13 (page 31)	Under "What action should they take?", we suggest that you may wish to add a reference to a specific health inequalities tool that is available now for all areas, including the Spearhead areas: Assess the potential impact (positive and negative) that all local plans will have on rates of CVD and related chronic diseases, including any potential impact on health inequalities. Use existing tools such as health impact assessments, and the Health Inequalities Intervention Tool."	Thank you. Unfortunately it is not possible to include comprehensive lists of possible tools in this guidance. Please note that NICE will be developing guidance on spatial planning that may consider a variety of tools used to examine health impact within the planning system.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4, Rec 13 (pages 31 – 32)	We suggest adding the following words to "Who is the target population?" - "*taking account of disadvantaged groups and areas.*"	Thank you. The format for these recommendations has changed to use the wording 'whose health will benefit'. The importance of assessing the potential impact on inequalities is included in the body of the recommendation.
Department Of Health		Section 4, Rec 15 (page 33)	NICE may wish to consider including a reference to the Healthier Food Mark scheme also under Recommendation 15.	Thank you. We understand the evaluation of Healthier Food Mark is not yet available
Department Of Health		Section 4, Rec 15 (page 33)	We suggest adding "*Government Departments*" to the list of public sector organisations who should take action.	Thank you. These have been added.
Department Of Health		Recommendation 16 (page 33)	The recommendation is about children and young people. Under "Who should take action", we therefore suggest adding Sure Start Children's Centres to the list.	Thank you. Managers of Children's centres have been added.
Department Of Health		Recommendation 17 (page 34)	On this recommendation about local and regional policy, we suggest strengthening "What action should they take?": By making it clear that action should be taken everywhere: Align Section 106 funding ('planning gain') with the promotion of heart health to ensure there is funding to support physically active travel in all areas, and to give people in disadvantaged areas access to affordable fruit and vegetables.	Thank you. This recommendation has been incorporated into recommendation 21 and now says 'Align all 'planning gain' agreements with the promotion of heart health to ensure there is funding to support physically active travel'.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4, Rec 17 (page 34)	We suggest adding the following words to "Who is the target population?" - "*taking account of disadvantaged groups and areas.*"	Thank you. The format of recommendations has changed so this now reads 'whose health will benefit?'
Department Of Health		Section 4, Rec 17 (page 34)	Under the heading "What action should they take?", we suggest you consider adding "*in all areas"* after "… to ensure there is funding to support physically active travel …".	This bullet is now contained in recommendation 21. The PDG felt that planning gain might not be an issue in all areas so this addition has not been made.
Department Of Health		Recommendation 18 (page 35)	The recommendation concerns physical activity and we suggest adding to "Who is the target population?": Whole population, taking account of disadvantaged groups and areas."	Thank you. The format of recommendations has changed so this now reads 'whose health will benefit?' This recommendation is now numbered 21.
Department Of Health		Pages 35 – 36	As background information, we would like to point out that many PCTs are already targeting those people disproportionately affected by CVD through the NHS Health Checks programme.	Thank you. The work of the NHS Health Checks programme in addressing those at higher risk of CVD is noted in recommendation 15. The main focus of this guidance is primary prevention of CVD.
Department Of Health		Section 4, Rec 19-24	We suggest adding the following words to "Who is the target population?" - "*taking account of disadvantaged groups and areas.*"	The wording of the recommendations has changed so this header reads 'whose health will benefit'. Recommendation 14 includes the action 'Identify groups of the population who are disproportionately affected by CVD and develop strategies with them to address their needs'

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Department Of Health		Section 4, Rec 21 (pages 37 – 38)	We suggest that NICE public health guidance on alcohol might be included in the list of NICE guidance to be followed when developing regional CVD prevention programmes at population level.	This guidance notes that it complements the guidance on alcohol misuse (page 4). However, it was not possible to include the alcohol guidance in the list to be followed when developing programmes as it was not published at the time of production of the CVD guidance.
Department Of Health		Pages 37 – 38, Recommendation 21	You may wish to change the second bullet point to: "Take account of ongoing, accredited vascular risk assessment programmes and screening activities by GPs and other healthcare professionals". The current sentence excludes the NHS Health Check which isn't a screening programme, as its main aim is not to search for existing disease. Rather, it seeks to identify possible risk factors for vascular diseases and offer lifestyle interventions to try and remedy this.	The PDG feel that it is appropriate to include NHS Health Checks in this grouping. To clarify this, they have been identified specifically. The bullet point (recommendation 15) now reads: 'Link the programme with existing strategies for targeting people at particularly high risk of CVD and take account of ongoing, accredited screening activities by GPs and other healthcare professionals. This includes the NHS Health Checks programme'
Diabetes UK		Section 2	When discussing risk factors – last paragraph: Please include "weight reduction where appropriate" as an approach to reducing risk.	Thank you. This section has been restructured and now includes a section on 'how these risk factors cause many other illnesses' which highlights the importance of diabetes and weight reduction.
Diabetes UK		Section 3.9	Whereas Diabetes UK recognises the need for and benefit of whole population approaches, the guidance document should also reflect the fact that specific interventions aimed at people at high risk are also valuable. NICE are developing guidance that focuses on preventing pre diabetes and preventing the progression of pre diabetes to Type 2 diabetes. At present the guidance could be misread as suggesting that such an approach is not valuable.	The PDG agree that both population and individual approaches are valuable. The final guidance includes a more detailed discussion of these issues (3.11-3.16). Paragraph 3.16 reads 'it should be noted that, as indicated above, population- and individual-based approaches are both important and can be complementary. They do not have to be considered as alternatives for CVD prevention.'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Diabetes UK		Section 3.30	The following references provide evidence of the efficacy of approaches that successfully encourage people to undertake physical activity: Jenum,AK. Anderssen,SA. Et al (2006) Promoting physical activity in a low-income multiethnic district: effects of a community intervention study to reduce risk factors for Type 2 diabetes and cardiovascular disease Diabetes Care 29 (7) : 1605 -1612 Kirk, A. Mutrie,N. et al (2004) Effects of a 12 month physical activity counselling intervention on glycaemic control and on the status of cardiovascular risk factors in people with Type 2 diabetes. Diabetologia 47:821-832 (this article also refers to a systematic review regarding the effectiveness of physical activity counselling in promoting behavioural change in the intermediate and long term)	Thank you for these references. The PDG feel that they are not relevant to this guidance, but they have been passed on to the team working on guidance on diabetes mentioned above.
Diabetes UK		Section 3.37	Diabetes UK welcomes the fact that NICE are developing guidance on the prevention of prediabetes in high risk groups and also on preventing the progression from prediabetes to Type 2 diabetes.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Diabetes UK		Section 3.38	This guidance should also consider the use of sugar, for example in processed foods. Added sugar is considered as "empty calories" and can lead to weight gain. Furthermore sugar consumption has been shown to increase triglycerides.	The PDG agree that sugar plays an important role. In particular, the considerations note that there is concern that sugar might be added when reformulating to reduce fat content which would reduce the benefit in terms of reducing calorie intake (3.42). The recommendationsalso support labelling of foods to indicate their sugar content, and restrictions on advertising of foods high in fat, salt or sugar to children (see for instance recommendation 4)
Diabetes UK		Section 4 Recommendation 1 Bullet point 4	It is recommended that children under the age of 5 and those who are malnourished consume full fat dairy products. Therefore this recommendation could exacerbate health inequalities for children under the age of 5 or those who are malnourished and on low incomes.	Thank you. The PDG agree with the current advice that in general children from the age of two can more to semi skimmed milk.
Diabetes UK		Section 4 Recommendation 2 Bullet point 3	Consideration should be given to how this recommendation will work in conjunction with FSA labelling guidance.	This bullet point (now bullet 10 in recommendation 1) now indicates that this labelling should be done using the FSA traffic light system
Diabetes UK		Section 4 Recommendation 3 Bullet point 1	This recommendation requires further explanation. At present the impact and implications of such a recommendation, are unclear.	Thank you. This bullet point (in recommendation 1) sets out the target for reducing population level consumption of salt. Implications on blood pressure of reductions in salt consumption are discussed in the considerations section (see for instance 3.21, 3.37-40)

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Diabetes UK		Section 4 Recommendation 4 Bullet point 2	This recommendation needs to reflect the need to make poly or mono unsaturated products more affordable. Also wherever possible to exchange the use of saturated fat with poly or mono unsaturated fat, ensuring that this does not increase the cost to the consumer.	This recommendation (2) aims to ensure that products are reformulated to contain lower levels of saturated fats, and for those with lower levels to be cheaper than high saturated fat equivalents
Diabetes UK		Section 4 Recommendation 8 Bullet point 1	Please include the entrance to swimming pools in this list of options, if VAT is applicable.	This recommendation (number 9) is about promoting physically active travel. Recommendation 21 (about physical activity) includes 'consider offering free swimming to parents and carers who accompany children aged under 5 years to swimming facilities'
Diabetes UK		Section 4 Recommendation 8 Bullet point 2	This recommendation needs to consider situations where not driving to work would significantly affect an individual's ability to conduct their lives effectively. For example parents who travel to take their children to school as well as arriving at work in good time, people requiring disabled parking spaces, or people who have to drive for their occupation. A recommendation could be made for incentives and support for people to access public transport. For example subsidising public transport. Individuals could then choose to increase their physical activity to and from a station or bus stop.	This recommendation (now 9) aims to identify and support physically active travel to help reduce CVD and other conditions. The PDG feel it is important to support the use of modes of transport other than car use where possible.

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Diabetes UK		Section 4 Recommendation 22 Bullet point 3	As part of a scheme that includes training, evaluation and quality assurance, volunteers can be a core resource for the delivery of CVD prevention activities. Diabetes UK has launched a risk assessment tool in partnership with the University of Leicester and Leicester University Hospitals, that helps to identify an individual's risk of pre diabetes and Type 2 diabetes. This complements the NHS Health Checks programme. Diabetes UK is training its volunteers to undertake risk assessments and provide basic information about the next steps for individuals who have been risk assessed. All volunteers will be recruited under a selection process, trained to quality assurance measures and peer reviewed. This scheme will be evaluated.	We look forward to hearing the outcome of the evaluation
Diabetes UK		General	In the recommendations that refer to healthier diet, it would be useful to include the consumption of oily fish, in line with relevant guidelines. This is important as guidance differs for people with diabetes or pregnant women for example. http://www.diabetes.org.uk/About_us/Our_Views/Position_statements/Fish_and_fish_oils/	The recommendations and considerations emphasise the importance of a balanced diet, for instance by supporting the 'eatwell' plate (see recommendation 20 and consideration 3.35)
Education for Health		3.7	Education programmes are crucial to ensure policy is implemented	While education has an important role to play it is not clear that it has a crucial role in the development of policy to achieve population level changes in CVD risk factors.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Education for Health		4	We would suggest that other organisations need inclusion in the suggested list on p23, particularly those in the Education and Public Health arena	These organisations, now listed on p8, are key in implementing the policy level recommendations (1-12). They include the DCSF and DH. Local organisations who should take action are indicated in each of the 'recommendations for practice' (13-24)
Education for Health		Recommendation 4	Likely to be very difficult to implement particularly in a time of recession	Thank you. This recommendation (now number 2) has been amended.
Education for Health		P27 bullet 7	Is this kind of detail really going to be valuable in helping change? Could the resource be used to support change?	Monitoring of levels of consumption in different groups in society is important to identify any need for change. These issues are addressed in recommendation 12.
Education for Health		general	It will be useful to re-awaken the realisation that policy and population approaches to improving health need to implemented systematically The suggested legislative aspects will support current drives to tackle obesity etc	Thank you. Population and individual approaches to improving health are discussed in more detail in sections 3.11-21
Fenland District Council		Recommendation 1	Reducing the price of lower fat dairy products may encourage low income parents of young children to opt for the cheaper lower fat option which is not appropriate for young children.	Thank you. The guidance now notes that semi skimmed milk is generally appropriate for children over two, in line with FSA recommendations.
Fenland District Council		Recommendation 2	Felt that traffic light and labelling information can be confusing and would be very difficult to be implemented by caterers and many food businesses	Thank you. The FSA traffic light system has been validated as an appropriate and understandable system

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Fenland District Council		General food industry	There is high emphasis on the food industry changing their products however irrespective of how low they can get their fat content etc that still does not stop an individual over indulging in any one day there is need for this document to reflect the fact that we need to get people to talk with their feet by not purchasing these higher fat foods through teaching about a balanced diet.	Thank you. The recommendations aim to incentivise healthier choices through promoting a healther environment rather than relying on individual choice. However, this approach will be supported by programmes which are complementary to the population level approach.
Fenland District Council		Recommendation 4	Should be all food products not just value ones.	Thank you. This recommendation (now number 2) has been amended.
Fenland District Council		Recommendation 5 Q1c	Should specifically say trading standards – this would not be the role of environmental health officers.	Thank you.
Fenland District Council		Recommendation 12	Great care has to be taken to balance our economy with our health issues	Thank you. The two issues are closely linked, however economic activity that damages the health of the local population is not beneficial.
Fenland District Council		Recommendation 16	Local authorities have limited influence over local businesses and do not have the funds to incentivise healthy eating scheme within premises not their own this is unrealistic and would need to be done so through national government such as free swim incentive – local authority can really only encourage.	This recommendation (now 19) has been changed. It aims to encourage local authorities and others, for instance on school trips, to use their purchasing power to encourage venues to provide affordable healthy options
Fenland District Council		Recommendation 8 Q1b	Within a highly rural area taxing car parking would drive people away form the towns spiralling income deprivation and increase social isolation for many.	Thank you. This recommendation (now number 9) has been amended. It now says 'consider and address factors which discourage physical activity, including physically active travel to (and at) work. An example of the latter is subsidised parking'.

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Fenland District Council		Recommendation 14 Q1a	These things are not currently covered in the course and to make changes in this it would need to come form the awarding body i.e. CIEH – they also specifically run other accredited course such as healthy eating and so are unlikely to want to change due to a potential loss of income.	Thank you. CIEH have been added to the list of those who should take action.
Fenland District Council		Recommendation 15	Please define clearly labelled – what do you mean by this?	Thank you. The bullet relating to labelling has been removed. The PDG felt that achieving the other bullet points would render this redundant.
Fenland District Council		Section 4 NHS and local authority CVD programmes	Believe all this section can be amalgamated together – we didn't feel it was beneficial at the workshop to go through each of the recommendations for this reason.	The PDG considered whether it was possible to combine recommendations 19 – 24 into one. However it was felt that this would not be helpful and so these are presented separately in the final document (recommendations 13-18)
Fenland District Council		General	Take aways are only being recommended to be addressed through planning policy without any other intervention being highlighted – the FSA are planning to work with take aways etc to provide guidance to improve nutritional quality of foods.	Recommendation 23 now contains an additional bullet points about working with take aways. This says 'Help owners and managers of take-aways and other food outlets to improve the nutritional quality of the food they provide'
Fenland District Council		General	Recommendations seem very sensible however are not within the enforcement powers of certain local authority teams.	Thank you. The PDG believe that the recommendations are within the powers of local authorities
Fenland District Council		General	Although the guidance may be what we are already doing however it acts as justification for that what we are doing is correct.	Thank you. This is an important point

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Fit - Fields in trust		Recommendation 18: Physical Activity	Action : it is suggested that the following fifth bullet point is inserted: • Encourage greater investment in maintenance and equipment of public, freely-accessible open space to encourage greater physical activity; Add another,ninth,bullet point: • Ensure that volunteer activity that promotes physical activity and provides leadership is encouraged and empowered. Promote collaboration between organisations, public, third sector and private, to encourage physical activity at all levels	This recommendation (now 21) has ben amended. Additional bullet points include ensuring the physical environment supports physical activity (linked to NICE guidance PH8) and ensuring the needs of children and young people to be physically active are met (linked to NICE guidance PH17). Promotion of collaboration with the third sector and others to promote physical activity, among other things, is addressed in recommendation 15

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Food and Drink Federation		General	I am writing to you on behalf of member of the Food and Drink Federation (FDF). FDF represents the interests of the UK's largest manufacturing sector. There are 7,000 food and drink manufacturers in the UK, employing around 440,000 people and generating annual turnover of £73bn. Our industry has a strong track record of responding to societal concerns about the health of the nation and our members have been showing real leadership over many years through voluntary action in areas such as nutrition labelling, reformulation, innovation, responsible marketing and workplace wellbeing. As the voice of that socially responsible and economically vital industry, we were pleased to attend the recent workshop led by Greenstreet Berman relating to the NICE draft recommendations on guidance for the prevention of cardiovascular disease at population level. We were however surprised on a number of points by what we learned at the workshop and are writing to record those concerns formally.	Thank you. The PDG is aware of the role of the food and drink industry in addressing many health issues to date, and this is acknowledged in the final guidance (see for instance recommendations 1 and 2, and considerations 3.38 and 3.47).

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Food and Drink Federation		General	Our comments fall into four main areas: 1. <u>Remit</u> We understand that the role of NICE in public health is to provide 'guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector' and that its primary remit is to provide advice to healthcare professionals. We believe that the draft guidance discussed at the workshop goes someway beyond NICE's remit – for example there are a number of areas commenting on national and EU regulatory or fiscal policies (such as the common agricultural policy) all of which are clearly the remit of Government and the European Institutions. All those parts of the guidance which do not provide practical meaningful guidance for healthcare professionals based on sound evidence (see below) should be deleted.	Thank you. The guidance presents a range of recommendations aimed at groups who play an important role in the prevention of CVD in the whole population. This includes setting out a number of potential policy objectives and actions to help reduce CVD. The decision on whether or not to adopt these policy approaches is rightly a political one. The guidance (page 8) notes that: '…the policy goals identified provide the outline for a sound, evidence-based national framework for action which is likely to be the most effective and cost-effective way of reducing CVD at population level. It would require a range of legislative, regulatory and voluntary changes including the further development of existing policies. The framework would be established through policy, led by the Department of Health and would involve government, government agencies, industry and key, non-governmental organisations working together. **The final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes**' [emphasis added].

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Food and Drink Federation		General	2. Evidence NICE's website makes it clear that NICE guidance should be based on the best evidence. We are not aware of any evidence to underpin a large number of the recommendations contained in the draft guidelines and NICE had not made any such evidence available. The guidance should contain only recommendations which are supported by clear evidence and any recommendations for which that evidence cannot be produced should be deleted. We do not believe it should be NICE's role to cut across the work of other public bodies and doing so risks causing confusion in terms of priorities and implementation of existing workstreams being taken forward on public health in partnership between government and industry such as that on salt reduction.	The evidence used to develop the guidance is indicated in appendix C. This consisted of a range of reviews commissioned for the development of the guidance, expert testimony to the committee, economic modelling and evidence provided to support the production of other related NICE guidance.

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Food and Drink Federation		General	3. Other current activity in this area You say that your aim of your guidance is to help healthcare professionals achieve the targets set out in the 2004 'Choosing Health' White Paper. Much work has been done by Government, industry and the third sector to improve the health of the nation since that White Paper was published and for many of the areas covered by the guidance a great deal of work is already underway (and has been for some time) by other competent authorities such as the Food Standards Agency. The draft NICE guidance appears not to recognise this and to take little account of processes which in many cases are already well-developed.	The aim of the referral is to produce public health guidance on the prevention of CVD at population level. Section 2 lists a number of government policy documents produced following the 'Choosing health' white paper. The PDG is aware of the processes and other organisations involved in addressing the premature deaths from cardiovascular disease and related conditions.

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Food and Drink Federation		General	4. <u>Process</u> Your website also makes it clear that NICE guidance should be 'transparent in its development, consistent, reliable and based on a rigorous development process'. We do not believe that NICE has lived up to that commitment in this case. Stakeholders appear to have had minimal input to this work which as we understand it has been largely driven by and based on the input of a small number of people on the Project Development Group (PDG). Whilst it is welcome that attempts are now being made to involve a broader set of stakeholders including industry we fear that at this late stage our ability to have a full discussion of the issues based on evidence may be limited. As a result the guidelines will fall short of NICE's own standards for its work and risk undermining the high reputation NICE rightly holds.	The guidance has been produced following the processes indicated in the NICE methods manual. This involves the collection of evidence, its presentation to an expert committee, discussion by that committee, development of draft recommendations before development of the final guidance. Involvement of stakeholders has included consultation on the scope, the evidence and on the draft guidance.

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Food and Drink Federation		General	Is there a role for guidance by NICE ? As noted above there is a great deal of relevant work already underway involving a number of players working in partnership. It may be that guidelines by NICE could play a useful role adding value for healthcare professionals and others working at local level to support public health, by drawing all this work together in a 'map' and providing recommendations on how healthcare practitioners tap into that activity to deliver meaningful interventions at a local level, ensuring they are consistent with, and complement, national activities. We urge you to consider this option and not to proceed with the guidance in its current form, which we submit falls a long way short of NICE's own high standards and will have no practical purpose or value for the busy professionals you are seeking to support.	Thank you. The PDG feel that it is important to identify and set out policy options (for consideration through the usual political process) to address CVD at population level. The final guidance also includes a range of recommendations for those involved in developing comprehensive CVD prevention programmes at a regional and local level

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		General	The Food Standards Agency's work is directly relevant to this consultation and we welcome the opportunity to comment on the draft recommendations. A key objective for the Agency is to improve the balance of the diet in order to reduce diet related disease, including CVD. Work under this objective with the food industry, catering sector and directly with consumers seeks to make the healthy choice the easy choice. To achieve this we: • provide extensive dietary advice for consumers of all ages through the 'eatwell' website (and other materials) and campaign activities; • encourage and support activity by the food industry as a whole to help bring dietary intakes to within public health recommendations through product reformulation, promotion of healthier options, and ensuring accessibility of smaller portion sizes; • promote informed choice through improvements in food labelling; and • review evidence across the range of the Agency's responsibilities to inform and develop policy. Elements of this programme of work also form part of a cross Government strategy for England on obesity and are reflected within the Department of Health's: 'Healthy Weight Healthy Lives' strategy.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		General	We note that NICE's guidance promotes a healthy balanced diet and covers proposals on key nutrients including salt, trans fats and saturated fats. We would, like to draw NICE's attention to the extensive body of work the Agency is taking forward with respect to these nutrients, as it is not clear how this has been taken into account by NICE in developing its recommendations. The Agency undertook a review of the health effects and current consumer intakes of trans fats in 2007; we are active on salt reduction at both UK level and internationally; and the Agency has a range of consumer awareness and reformulation activities underway via its Saturated Fat and Energy Intake Programme which was published in 2008. Our priorities are to reduce intakes of salt and saturated fat, whilst maintaining the progress that has been made by the food industry to reduce the levels of artificial trans fats in foods.	The PDG is aware of the work of the FSA and the final guidance acknowledges this work and the progress made to date. The view of the PDG is that it is important to update the position with regard to IPTFA, in particular to take into account their potential impact on CVD in some groups.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		General	We are concerned that some of NICE's recommendations relating to intakes of individual nutrients do not reflect Government public health advice. Current advice is based on the recommendations of independent expert bodies charged with advising Government in these areas. Chief among these on nutrition is the Scientific Advisory Committee on Nutrition (and its predecessor, COMA). The basis for departing from these recommendations is often unclear, and we would welcome an opportunity to review with NICE the evidence that supports this.	The guidance builds on recent progress and aims to produce recommendations, based on the evidence presented to the committee.
Food Standards Agency		General	We would also encourage NICE to discuss with the Agency and other relevant authorities EU and national legislative processes, as these will determine the feasibility, benefits and costs of implementing any recommendations NICE may make for legislation.	Thank you. The PDG feel that the amended final guidance takes these issues into account.
Food Standards Agency		General	We welcome NICE's support of the 'eatwell plate' in promoting consumption of a healthy balanced diet, and recognition of the importance of front of pack labelling as a tool for consumers to make healthier choices.	Thank you
Food Standards Agency		Page 7	No reference is made to the FSA's Strategic Plan 2005-2010	Unfortunately it is not possible to produce a comprehensive list of all potentially relevant documents

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		3.13 (page 13) 3.22 (page 16)	We support the principle that all sectors including the food industry have an important role to play in helping to tackle CVD, and we note that much work has already been undertaken. Acknowledgement should be given to the significant progress made by the food industry so far working in voluntary partnership with Government to reduce levels of salt, saturated and trans fats (by reformulation) in their foods.	The final guidance acknowledges the significant progress made to date (see for instance recommendations 1 and 2, and considerations 3.38 and 3.47)..
Food Standards Agency		3.22 (page 16)	No acknowledgment is made of the work already ongoing to reduce the amount of salt, saturated and trans fats in food.	This is acknowledged in the final guidance.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		3.24 (pages 16-17)	**Trans fats**. It is not clear how the guidance takes account of the Food Standards Agency's (FSA) review of trans fats in 2007; the Scientific Advisory Committee on Nutrition's review of evidence of the health effects of trans fats, or the decision by Health Ministers to accept the FSA's advice that voluntary action by UK food companies had reduced artificial trans fat levels in the foods they produce to a minimum, and average dietary intakes (at around 1% of energy) to within the UK public health maximum recommended average intake. Ministers agreed that legislative action was unlikely to bring about significant additional public health benefits to the general population. The Government's priority is therefore to reduce saturated fat intakes whilst maintaining the progress made on trans fats. No new evidence has been presented to support a linear relationship between intake and CVD risk and therefore that there would be significant consumer benefit of reducing intakes to levels below 1% of energy. We believe therefore that NICE's estimates of lives saved may be too great. We would welcome new evidence and consider this as it becomes available.	The view of the PDG is that it is important to update the position with regard to IPTFA, in particular to take into account their potential impact on CVD in some groups.

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Food Standards Agency		3.25 (page 17)	**Saturated fats** NICE guidance does not appear to take account of current UK public health recommendation that population average intakes of saturated fat, agreed by Committee on Medical Aspects of Nutrition Policy (COMA), should not exceed 11% of food energy. Sugar intakes of the general population, and children particularly, exceed public health recommendations. Any action to reduce saturated fat intake should not exacerbate this. We would like to draw attention to the FSA's Saturated Fat and Energy intake programme, which is working to reduce intakes of saturated fat and energy through actions to: • improve consumer awareness and understanding of healthy eating with particular focus on the impact of saturated fat on health; • encourage greater promotion of, and increased uptake of healthier options e.g. reduced fat products and manufacturers' and retailers' 'healthier' ranges; • encourage increased accessibility of smaller food portion sizes; and • encourage voluntary reformulation of mainstream products to reduce saturated fat and energy.	Thank you. The final guidance notes that there is potential benefit in reducing saturated fats below this level. Consideration 3.42 notes the risk of replacing saturated fat with sugar.

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Food Standards Agency		3.25 (page 17)	In 2009 the FSA launched a consumer awareness campaign and two consultations of recommendations targeted at the food industry. The consultations focus on foods which are significant sources of intake of saturated fat, or energy (from sugar) namely : biscuits, cakes, confectionery, pastries, sugar containing soft drinks, dairy and meat products, and savoury snacks. The FSA would be happy to provide further details of these activities and the progress to-date.	Thank you.

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Food Standards Agency		3.26 (page 17)	The FSA has an extensive programme of work on salt which includes three strands of activity: (1) development of salt targets (2) increasing public awareness of the health impact of consuming too much salt and how consumers can reduce their intakes; and (3) improved nutrition labelling to help consumers identify healthier lower salt choices. Voluntary activity on salt reduction began in 2003/4, has proven very successful thus far. The voluntary approach provides flexibility both in the type of targets which may be set (averages as well as maxima), and the speed at which they can be revised. NICE should note that voluntary targets were introduced only in 2006 and these targets were reviewed in 2008. New stricter targets have been set for 2010 and 2012 to ensure continued progress in salt reduction. On what evidence can NICE claim that success is only possible with the introduction of additional regulatory action is based? Any regulatory action at a national level would be subject to agreement by the European Commission and Member States as part of the procedures for the notification of technical standards.	The final guidance acknowledges the progress made to date on reducing salt. The guidance emaphasises the benefits to be achieved from further rapid reduction in salt intake and identified policy options to achieve this.

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Food Standards Agency		3.27 (page 18)	FSA estimates that a reduction in mean salt intake of 3g equates to around 20,200 fewer deaths from CVD annually, which equates to gaining 172,000 (not 130,000 as quoted) QALYs annually. This is equivalent to an overall saving of £5.1bn annually. It is not clear why the PDG has highlighted a 6g reduction in salt intakes, as this would reduce consumers intakes to levels below the Reference Nutrient Intake of 4g/person/day.	Thank you. The figure of 130,000 QALYs annually was derived from the economic model, which used a number of conservative estimates. The higher figure indicated here would suggest even greater benefits. The PDG is aware of evidence that suggests health benefits and cost effectiveness in reducing salt intake to 3g a day.
Food Standards Agency		3.3.1 (page 19)	There are wider positive benefits from a maternal diet meeting Government guidelines in relation to the development of adult diseases later in life within the offspring.	Thank you. There are important benefits from a maternal diet which meets guidelines. These are addressed in NICE public health guidance 11, which is referenced in recommendation 15.
Food Standards Agency		Recommendation 2 (page 25)	Legislation already exists which relates to the provision of nutrition information on food. The EU is currently negotiating new Food Information Regulations which includes provisions relating to front of pack labelling. FSA, on behalf of the UK, is negotiating to maintain Member States' flexibility to provide additional nutritional information and present it in a way which meets their consumers' needs.	Thank you. The PDG agree clear, consistent labelling is very important. Recommendation 6 aims to ensure that the FSA's integrated front of pack labelling is established as the national standard and that the UK continues to set the standard for Europe
Food Standards Agency		Recommendation 2 (page 25)	**Restrictions on Advertising** The Agency criteria for a green traffic light, denoting low levels of salt, fat , saturated fat and sugars was developed specifically for use in front of pack labelling. The suitability of these criteria for wider use would need to be assessed before proceeding.	This bullet point has been deleted. Recommendation 4 looks at advertising and children and recommends a 9.00pm watershed for TV advertising and equivalent standards for non-broadcast media.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		Recommendation 2 – (page 25)	**High salt labelling** The FSA's front of pack labelling scheme enables consumers to identify whether a food is high in salt. The range of foods for which provision of front of pack labelling should be recommended was the subject of the FSAs recent consultation. The Agency will be providing its advice to Ministers on the scope and application of front of pack labelling in March 2010. We are aware that this approach is used in Finland. It is not clear how helpful this additional labelling would be to UK consumers who are already familiar with front of pack labelling schemes. Nutrition labelling of foods is an area where EU harmonised rules apply and the UK could not introduce such requirements unilaterally. To give effect to the third bullet point in this recommendation would be problematic.	Recommendation 1 now says 'Clearly label products which are naturally high in salt and cannot meaningfully be reformulated. Use the Food Standards Agency-approved traffic light system'

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		Recommendation 3 – salt (page 26)	**Promoting the benefits to the EU and introducing national legislation** The FSA has a strategic objective to reduce salt intakes to no more than 6g a day for adults and lower levels for children. The UK has been a strong advocate of salt reduction internationally. The European Commission is already aware of the benefits of salt reduction and has a programme of work in place in this area which is modelled on the UK approach. The majority (25/27) of member states are already signed up to this. The FSA is working with the UK food industry in voluntary partnership to reduce levels of salt in a wide range of foods that contribute most of the salt to our dietary intakes. This voluntary approach provides the flexibility to review and revise salt targets more quickly than legislation. The FSA has made clear that it will consider the need for legislative measures should the voluntary approach prove unsuccessful. Cont…	Thank you. Recommendation 1 acknowledges the progress made to date. It emphasises the benefits of reducing salt intake, and of progression beyond 6g
Food Standards Agency		Recommendation 3 – salt (page 26)	We do not consider that legislation is necessary at present. Further data from the FSAs urinary sodium survey will provide us with a measure of progress in reducing salt intakes in 2011.	Thank you.

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Food Standards Agency		Recommendation 3 – salt (pages 26)	**Continue to reduce the salt content of commonly consumed foods …** The FSA has a set of voluntary salt reduction targets for 80 different categories of foods including the most commonly consumed. These targets were initially set in 2006 to be achieved by 2010. Revised targets were published in May 2009 to be achieved by 2012. These encourage the UK food industry to make gradual reductions in the levels of salt in the foods they produce and applies to all types of food products (eg low cost, standard and luxury). This stepwise gradual approach is needed to maintain acceptability while consumer palates adjust.	Thank you. The PDG note that it is important that progress towards a low-salt diet needs to be accelerated as a matter of urgency
Food Standards Agency		Recommendation 3 – salt (pages 26)	**Agree EU salt targets for processed foods. Ensure salt levels are monitored in commonly consumed foods…at EU level and nationally** As part of its programme of work the EU already has targets for levels of salt in processed foods – it requires members states to reduce levels of salt in these foods by 16% over 4 years (commencing 2009). It also has plans in place to monitor reductions via monitoring within each member state. The (UK) FSA has a programme to monitor progress towards its salt targets and the levels of salt in a wide range of foods using sales and nutrition label data.	Recommendation 1 now says 'support the Food Standards Agency so that it can continue to promote – and take the lead on – the development of EU-wide salt targets for processed foods'

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Food Standards Agency		Recommendation 3 – salt (pages 26)	**Reinforce and review national targets for salt intake among the population .....** As part of its public awareness activities the FSA already promotes consumer awareness that adults should aim to have no more than 6g salt per day and that children should have less (highlighting the age-dependent figures set by SACN in 2003). The Agency has run 4 phases of consumer activity since 2004; the most recent was in October 2009. SACN receives regular updates on progress in salt reduction and in the event that new robust evidence of sufficient power becomes available on the health effects of salt SACN would review this as part of its work programme. Timetables for achieving the Agency's salt targets have been set (see previous comment). The next progress review will take place in 2011 and will look at levels of salt in foods and dietary intakes via urinary sodium analysis. The FSA has made a commitment to review progress on a biennial basis.	The guidance acknowledges the progress made to date and suggests future targets of 6g by 2015 and 3g by 2025
Food Standards Agency		Section 4 Recommendation 4 (pages 26)	**Saturated fats**: See also comments on section 3.25 The rationale for departing from COMA advice and the evidence base for a recommendation to reduce saturated fat intakes to 7% of total energy is unclear.	The evidence suggests that reductions in CVD can be achieved with lower intakes than the current pragmatic advice

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		Section 4 Recommendation 4 (pages 27)	**Tax on high saturated fat food** The FSA would welcome sight of the evidence of the impact of fiscal penalties on dietary intakes, and reassurance that such an approach does not have the effect of increasing health inequalities.	This bullet point (recommendation 2) now says 'Create the conditions whereby products containing lower levels of saturated fat are sold more cheaply than high saturated fat products. Consider legislation and fiscal levers if necessary'
Food Standards Agency		Section 4 Recommendation 4 (pages 27)	**Reformulation of all products and remove trans fats** To ensure a proportionate approach which will offer the greatest consumer benefit it would be helpful to focus industry efforts towards those foods which contribute most to saturated fat intakes. The FSA's recommendations for saturated fat reduction in foods cover luxury and value ranges.	This bullet point has been amended. It now says 'Encourage manufacturers, caterers and producers to reduce substantially the amount of saturated fat in all food products. If necessary, consider supportive legislation. Ensure no manufacturer, caterer or producer is at an unfair advantage as a result'.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		Recommendation 5 (page 27)	**Trans fats** The evidence base for the NICE Recommendation to reduce intakes of trans fats to 0.5% of energy for all individuals is unclear. The SACN report noted that estimates of risk from epidemiology for quintiles of intake in the region of 1-2% food energy do not differ significantly from 1%. RCTs have also compared levels of TFA intakes between 1-2% food energy on lipoproteins. Therefore there is limited evidence to suggest a benefit from intakes below 1% food energy to change the recommendation. We recommend that the PDG consider the information presented in the Agency's Board paper on trans fats of December 2007, about the levels of trans fats in oils supplied by UK fats and oils suppliers. Reported trans levels were generally <1%. It would be helpful for the FSA to have sight of the cost benefit assessment undertaken for the proposal to introduce legislation to ban artificial trans fats. It should be noted that an accurate method of analysis that distinguishes between artificial and naturally occurring trans fats, and which would be necessary for effective enforcement of any legislation is not currently available.	This recommendation (3) has been amended. The aim of the recommendation is to eliminate the use of IPTFAs for human consumption by restricting IPTFA levels in the fats and oils used in food manufacturing and cooking. The view of the PDG was that it was important to address the consumption of IPTFAs in different groups in the population and not to rely on average intake data.

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Food Standards Agency		Recommendation 5 (page 27)	There are technical considerations associated with the replacement of saturated fats with poly- or mono-unsaturated fats. For some foods including pastries, cakes etc saturated fat plays a structural role and there will be limitations on the level of substitution that will be possible, while retaining the integrity and consumer acceptability of the product.	Thank you. International examples suggest that these technical considerations are surmountable.
Food Standards Agency		Recommendation 6: (page 28)	**Guidelines in catering** The FSA welcomes the recognition of the usefulness of this guidance for those serving food in major institutions. We note that this guidance is in keeping with Government recommendations and would suggest that other recommendations for nutrient intake are kept consistent with this approach. We further note that the Government (England) are currently piloting the Healthier Food Mark (towards healthier more sustainable food provision in the Public Sector). The gold level standards on the nutrition elements of this mark are in keeping with FSA guidance for major institutions. Encouragement to public sector organisations to sign up to this work would be useful.	Thank you. The recommendation (10) includes a bullet point about assessing the effectiveness of the Healthier food mark pilot and development of a timetable to implement it if successful.

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Food Standards Agency		Recommendation 7 (page 28)	**Catering** It is important that the nutritional quality of food eaten outside of the home improves in parallel with that of manufacturers and retailers, and that consideration is given to food provided through the private as well as the public sector Encouragement to caterers (high street chains, takeaways, pubs, staff canteens, etc.) to improve the nutritional quality of their foods should be included here. Working with the catering sector is a key part of the *Healthy Weight Healthy Lives* Healthy Food Code of Good Practice and is in line with the recommendations of the PMSU *Food Matters* report. Over the past 2 years the Food Standards Agency has worked to secure public commitments from major catering companies to make it easier for consumers to eat more healthily outside of the home. Over 40 of the largest catering companies in the UK have provided commitments which cover procurement, menu planning, kitchen practices and consumer information.	This recommendation (now 11) looks at planning controls on food outlets. Recommendations 23 and 24 also look at improving the nutritional quality of the food they provide

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food Standards Agency		Recommendation 7 (page 28)	The Healthy Food Code of Good Practice also challenges businesses to provide nutrition information in catering outlets. The Agency is currently developing a guidance document for companies who wish to voluntarily provide calorie information at point of choice in such outlets. This will be based on the experiences of 21 major catering companies who introduced calorie labelling in summer 2009, with independent research assessing how easily customers understand and use such information. The guidance will be published in early 2010. A third strand of the FSA's work is with small catering businesses (which make up around 98% of catering businesses). The overall objective is to improve the nutritional value of foods offered in these businesses, focussing on the key nutrients of public health concern and building on current FSA work on reducing salt, saturated fat and energy intake. The strategy focuses on providing practical, targeted advice on healthier catering to small business sectors, e.g. fish and chip shops, Indian restaurants.	Recommendations 23 and 24 also include bullets to support the improvement of the nutritional quality of food provided and improving frying practices.
Food Standards Agency		Recommendation 9 (page 29)	**Health impact assessment** These are carried out as a matter of course for major policy initiatives, and form part of public consultations.	Thank you.

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Food Standards Agency		Recommendation 10 (page 30)	**Commercial interests – meetings are conducted in a transparent way** The FSA is a government department that has always promoted its approach to openness and transparency. The FSA has published on its website the Principles governing its policy on the publication of FSA information and the Protocol for the Publication of Minutes of Meetings. These are consistent with the principles set out in the Information Commissioner's Office's Model Publication Scheme. In addition, as a public authority under the Freedom of Information Act 2000 (FOI) the FSA has, like all other government departments, a legal responsibility to locate all appropriate information that falls within the scope of any request and to take appropriate decisions about its disclosure. FOI is predicated on a presumption that requested information will be disclosed unless there is a legitimate reason not to do so. Cont…	Thank you. This recommendation (5) aims to support public health objectives and disclosure of interests in line with best practice. The recommendation now says 'Encourage best practice for all meetings, including lobbying, between the food and drink industry and government (and government agencies). This includes full disclosure of interests by all parties. It also involves a requirement that information provided by the food and drink, catering and agriculture industries is available for the general public and is auditable.'

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Food Standards Agency		Recommendation 10 (page 30)	Although publication of information serves the public interest, there may be circumstances in which the balance of public interest may be against publication. The FSA is quite often placed in the position of having to consider the potential disclosure of information that has been supplied to it by third parties, which those providing it deem to be either commercially sensitive and/or to have been provided in confidence. It is in the public interest that Government is able to have free and frank discussions with stakeholders in developing its policies and that they are not deterred from providing advice because it might later be disclosed. The FSA may therefore withhold information where its publication would be likely to prejudice the effective conduct of public affairs by discouraging the sharing of information.	Thank you. This recommendation (now number 5) aims to 'ensure dealings between government, government agencies and the commercial sector are conducted in a transparent manner that supports public health objectives and is in line with best practice. (This includes full disclosure of interests.)'
Food Standards Agency		Recommendation 14: (page 32)	**Training** The Food Standards Agency welcomes the recognition of the importance of training for caterers and the importance of basing this on the eatwell plate. We note, however that such training should be consistent with UK recommendations. We further note the positive work already being commenced with the Sector Skills Councils however a mandatory course requires new primary legislation. Inclusion as part of the National Occupational Standards should be encouraged,	Thank you. This recommendation (24) now says 'Ensure the links between nutrition and health are an integral part of training for catering managers'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		1. Key Priorities	We believe that for the consultation process to be fully effective, the Key Priorities should have been identified before the start of the consultation period.	Thank you. The key priorities will vary depending on the view point of the prioritising body. As a result, the PDG has not prioritised the recommendations
Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 3 (P25)	Although the recommendations refer to food manufacturing and processed food, no reference is made to foods served in catering premises (restaurants, cafes, take-aways etc). For many people these provide a significant proportion of the food (and salt) that they consume. Whilst some of the national chains of catering businesses have started to consider how they can reduce the level of salt in the food that they serve, this is not the case for the majority of small independent businesses. The recommendations should include proposals for how this might be achieved.	Food served in catering premises is addressed in several recommendations in the final document. These include recommendation 19 (when public money is used to procure food and drink in venues outside the direct control of the public sector)' recommendation 20 (public sector food provision) recommendation 23 (take aways and other fast food outlets) and recommendation 24 (nutrition training)
Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 5 (P27)	The recommendations include a proposal to independently monitor the level of trans fats in processed and take away food. They should be expanded to set out how this might be achieved in practice and what action should be taken where levels are found to be unsatisfactory.	Recommendation 3 includes the bullet '…introduce legislation to ensure that IPTFA levels do not exceed 2% in the fats and oils used in food manufacturing and cooking'. Sanctions to address failure to meet this standard would be part of legislation if this were to be adopted following the usual political processes.

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Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 6 (P28)	The recommendations should be extended to include the whole range of catering premises including restaurants, cafes, take-aways etc.	The aim of this recommendation (now 10) is to address the provision of food in the public sector where there is a greater degree of control
Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 7 (P28)	We do not agree that "Local planning authorities are able to control fast food outlets". Having discussed this issue with colleagues in the planning service both locally and regionally, with a view to taking action to control the number of take-away premises, we are advised that the introduction of such controls is not possible or at the very least fraught with problems. We are aware that within a small number of local authorities action has been taken to limit the number of take-way premise close to schools, however this is only one small aspect of a major problem. More important is the total number of premises supplying food of this type. Location is in many cases irrelevant as a significant proportion of the food sold is delivered by delivery drivers or local private hire vehicles. We suggest that this issue should be raised with the relevant national government departments to clarify exactly which legislation can be used and publicise this widely along with practical guidance on implementation.	The PDG acknowledge that this is a complex issue. However the recommendations are intended to encourage the further use by Local Authorities of their existing powers to restrict premises.

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Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 7 (P28)	We are unsure what is meant by the recommendation to "Link this legislation to food hygiene regulations". Does that mean a condition of planning approval would be compliance with food regulations (and presumably healthy eating requirements) as a pre-requisite. If so, why should these controls not apply to all food businesses? The focus seems to be on preventing new premises from opening. We are more concerned about the food served by both new and existing businesses and practical proposals as to how this could be made more healthy.	Thank you. This bullet has been removed. Recommendations 23 and 24 also address nutritional quality and cooking practices in these premises.
Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 12 (P31)	We do not believe that this action should be limited solely to premises located near to schools. It should be extended to cover the sale of food to the wider population. Also: See comments regarding Recommendation 7 above.	Thank you. This bullet (now in recommendation 23) has been amended so that it is not exclusively about premises near schools.
Greater Manchester Food Liaison Group & Greater Manchester Food Standards Group		Recommendation 14 (P32)	We support the proposal to expand hygiene training for caterers to include the links between nutrition and health. However, this should be achieved by an increase in the overall duration of the course and not by a reduction in the hygiene element.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
GE Healthcare		General	We applaud the recommendations to prevent/reduce cardiovascular disease in UK.	Thank you.
GE Healthcare		Section 4	I think the Health Impact assessment should not only be done by Local Government but jointly with the Health Sector. By working hand in hand, that is both Local Authorities and the National Health Service – a whole systems approach can be adopted to assessing and developing implementation plans for the local populations.	Thank you. Recommendation 22 is aimed at both local policy makers and PCTs.
GE Healthcare		General	The Government announced vascular checks for the over 40's to start in April this year. This if implemented will be a step in the right direction. This needs to be extended to "high risk" patients as well.	The PDG feel that the population level recommendations in this guidance are complementary to the individual approach of the NHS Health Checks programme.
GE Healthcare		Section 4	It would be useful if the recommendations include some guidance and information to employers so that there are more supportive actions for staff to improve healthy lifestyles. For example at GE we have launched "healthymagination" which includes providing staff internally with the tools and providing information on the benefits of a healthy lifestyle as well as the risk factors of cardiovascular diseases.	The NICE guidance on workplace programmes on smoking and on physical activity are referenced in recommendation 15.
GE Healthcare		Section 4	Earlier detection and diagnosis has to go hand in hand with any preventative strategies to ensure that people are diagnosed early enough to improve patient outcomes and ensure effective and targeted treatment occurs.	The aim of this guidance is to address primary prevention at the earliest stage to reduce the need for individual diagnosis.
Heart of Mersey		General	Heart of Mersey strongly supports a population-based approach to preventing CVD which should be an essential element of any approach which seeks to address health inequalities.	Thank you.

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Heart of Mersey		General/ Section 4/ Recommendations 11, 16	Heart of Mersey welcomes the emphasis placed on the importance of taking action at an early stage to prevent the development of CVD risk factors amongst children.	Thank you
Heart of Mersey		General/ 3.16	Heart of Mersey also supports the acknowledgment that "the role of voluntary and community sector groups and organisations in CVD prevention is important".	Thank you.
Heart of Mersey		Section 4/ Recommendation 5	We strongly support a ban on industrial trans fats as introduced in Denmark and in parts of the USA such as New York City. There is growing evidence that there is a higher intake of trans fats amongst children and young people due to a higher content of TFAs in take away food which also contributes to increased health inequalities.	Thank you. These issues are now covered in recommendation 3
Heart of Mersey		Section 4/ Recommendations 19-24	Heart of Mersey gave evidence to the PDG relating to regional CVD prevention programmes. Recommendations 19-24 note the importance of a population-based approach as well as strategies for targeting people at high risk of CVD. However there is no action noted in this section about how local policies (such as those included in Recommendation 18) can contribute to a population-based approach to CVD prevention. This could be more explicit in Recommendation 21 with the addition of a new bullet point e.g. Ensure local policies concerning transport, planning and food retailing consider the potential impact on CVD.	Thank you. Recommendation 15 now says 'work closely with regional and local authorities and other organisations to promote policies which are likely to encourage healthier eating, tobacco control and increased physical activity. Policies may cover spatial planning, transport, food retailing and procurement'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Heart UK		General	HEART UK welcomes this draft guidance which outlines important strategies for public health intervention to reduce cardiovascular disease rates through population based primary prevention	Thank you.
Heart UK		Section 2 Page 5-6	In describing the most important potentially modifiable risk factors for myocardial infarction, the draft refers to Yusuf et. al 2004 (the InterHeart Study). This reference should be quoted accurately – the risk factor ranked highest in terms of population attributable risk was the apolipoprotein B/A1 ratio not "high blood cholesterol". In a subsequent publication for InterHeart, McQueen et al showed that apolipoprotein B/A1 ratio was superior to any cholesterol related parameter. It would seem appropriate to list the risk factors in the rank order reported by the authors and using their descriptors	Thank you. The document refers to the Yusuf study, however it is not intended to be a direct quote from it. In a document with a wide readership there is a balance between technical terminology and understandability. The reference allows those who need the full details to find them from original source
Heart UK		3.2	CVD risk factors can be reduced by providing information , advice and prescribing treatment – identification of high risk groups for targeting interventions	The guidance notes that there are a range of different ways of reducing risk factors. See for instance sections 3.11 - 21
Heart UK		3.3 and 3.4	To date prevention and treatment efforts have been concentrated on older individuals and with greater emphasis on secondary rather than primary prevention. The lack of improvement in CVD death rates among young people might be partly attributable to these factors.	Thank you. This agrees with the comments in 3.14 and 3.22

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Heart UK		3.7	Reference should be made to the difficulty of implementing evidence based guidance including that formulated by NICE	The process of implementing policy recommendations such as those in this guidance would require a range of legislative, regulatory and voluntary changes of existing policies. The guidance notes that 'the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes'.
Heart UK		3.9	It should be emphasised that population based and individual risk factor interventions are complementary, not competing alternative strategies – avoid using "rather than"	Thank you. This is clarified in para 3.16
Heart UK		3.12	In highlighting the difficulty of successfully implementing behavioural change in disadvantaged groups, the importance of individual risk factor intervention and identification of those at greatest risk (e.g. through health checks or family tracing) should be emphasised	Thank you. The PDG feel that a population level approach is likely to reduce inequalities. Recommendation 14 includes 'identify groups of the population who are disproportionately affected by CVD and develop strategies with them to address their needs'
Heart UK		3.19	Abnormal blood lipids (as ranked highest among CVD risk factors by Yusuf et al.2004) should be given appropriate prominence here and mention should be made of the importance of gene-environment interaction in modulating the effect of risk factors	Thank you. Abnormal blood lipids a key risk factor for CVD. Para 3.2 identifies as the key CVD risk factors that can be modified: smoking, a poor diet, obesity, lack of physical activity and high alcohol consumption

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Heart UK		3.32	The importance of identifying children with Familial Hypercholesterolaemia (as recommended in NICE Guideline CG71) should be highlighted here.	Familial hypercholesterolaemia is a serious inherited condition which is estimated to affect 1 in 500 children (most of them currently undiagnosed), as such, a population approach to its management is not appropriate. NICE guideline CG71 recommends identification through family tracing and does not recommend a population approach. The care of children with FH would include a diet much like the one proposed for the population
Heart UK		4 page 37	Recommendation 21 – Should cross reference NICE CG67 and CG71	Thank you. This guidance is aimed at addressing CVD in the general population rather than in specific patient groups.
Heart UK		4 page 38 and Appendix D 4	Recommendation 22 – as an example pilot studies undertaken with DoH support to evaluate strategies for family cascade testing in Familial Hypercholesterolaemia and cited in CG71 were not continued	Thank you
Heart UK		5 – p 39 Implementation	Should cross reference NICE CG67 and CG71	Thank you.
Heart UK		8 p 41 Related NICE guidance	Should cross reference NICE CG71	Thank you
Heart UK		3.16 and 4 page 24	HEART UK should be identified as a “key player”	The organisations indicated here are examples. This list is not intended to be comprehensive

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Heart UK		Page 27, Recommendation 4	Last paragraph. "Remove trans fat" - only needs to be in recommendation 5	Thank you. This has been deleted. The recommendation on IPTFA is now number 3.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Institute of Food Science and Technology		General	I am writing to you on behalf of members of the Institute of Food Science and Technology (IFST). IFST is the Independent Professional Qualifying Body for Food Scientists and Technologists. Members are individuals who work and have worked in food and drink manufacturing and retailing, universities, research establishments, consultancy, food law enforcement and government. One of our principal objectives is to serve the public interest by furthering the application of science and technology to the supply of safe, wholesome, nutritious and attractive food. We recognise that NICE intended to review guidance on the prevention of cardiovascular disease at population level. Nevertheless we bear in mind that it is likely that its recommendations may be widely interpreted at the individual level. We agree with the overall objective of these recommendations and realise that the population is often confused by different sources of information. A consolidated opinion from such a recognised body as NICE would be an important position and would be extremely useful to those healthcare professionals operating at a population level. We feel that NICE is well placed to present this but that any recommendations should be offered as guidelines rather than specific recommendations which run the risk of getting embroiled with the remits of other organisations.	The final guidance clarifies its position in producing recommendations for the population level prevention of CVD (see for instance para 3.11). Paras 3.7 and 8 note that a consistent message on lifestyle risk factors is important and that the recommendations in this guidance are not intended to replace existing advice to the public on diet.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Institute of Food Science and Technology		General	Our comments are as follows: 1. <u>Remit</u> Some of the recommendations require legislative action, either national and/or European; however, we believe these recommendations should be attainable without need for changes at a legislative level. We are unclear exactly where this initiative sits in relation to other government-sponsored initiatives in this area. 2. <u>Evidence</u> The guidance should contain only recommendations which are supported by clear and up-to-date evidence. The evidence should encompass broader life-style issues and also needs to include an economic analysis so that there is a calculation of the risk/benefit. Whilst seeking an increasingly lower level of salt/ trans fat/ sat fat etc. in our diets there becomes a point where additional benefit is minimal relative to the technological hurdle and the costs involved.	The guidance presents a number of evidence based policy options to reduce the population level CVD burden. As the guidance notes, 'the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes' As indicated in the guidance, the recommendations are based on evidence, including economic modelling. Evidence indicates that there is a substantial burden of premature deaths from CVD that could be addressed by the recommendations in the guidance.

PUBLIC HEALTH PROGRAMME GUIDANCE – CARDIOVASCULAR DISEASE

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Institute of Food Science and Technology		General	3. <u>Balance of food sources</u> Manufactured foods represent disproportionate target in these recommendations. Our food intake is spread across a number of options, manufactured foods being just one. Other impacts on our dietary balance are restaurants/ fast food outlets, institutional foods such as school, hospitals and prisons and, most importantly and increasingly, scratch cooking in the home. A great deal can yet be achieved in the out of home market where the nutritional balance is not top of mind and technical knowhow often limited. Also in-home cooking requires a greater level of education than currently with regards to nutritional balance and the influence it has on CVD. Healthcare professionals are particularly well placed to impact in-home education. 4. <u>Balance of targets</u> We also feel that the overall link between CVD and obesity has not been highlighted in any significant way and this should be one of the main stays of the recommendations linking with food intake and exercise. We urge you to consider these opinions when progressing the recommendations to their final form. We applaud NICE for seeking to coordinate this position and suggest that continued involvement with the full range of stakeholders will be essential to ensure that the overarching recommendations/ guidelines are sound and achievable.	Recommendations target a range of sectors, including fast food/take aways and public sector catering. Thank you. Obesity is highlighted in the final guidance as one of several modifiable risk factors for CVD, and the existing NICE guideline is included in recommendation 15.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Institute of Health & Society, Newcastle University		General	Congratulations on an excellent guidance document – really great to see recommendations that focus on population benefit and clearly identify who needs to act.	Thank you.
Institute of Health & Society, Newcastle University		3.9	Strongly support the population approach, but it may be helpful in advocating this to recognise its limitations, so that they can be addressed when intervening. For example, Rose's proposals for the most part assumed a (more or less) linear relationship between risk and outcome – but this is not always the case (including for example with BP or alcohol and CVD) and the importance of the J or U-shaped relationship needs to be acknowledged. Rose also made little of the fact that population interventions don't always affect everyone equally – knowing when they do and don't is important. See: Adams J, White M. When the population approach to prevention puts the health of the individual at risk. *International Journal of Epidemiology* 2005;34:40-43. White M, Adams J, Heywood P. How and why do interventions that increase health overall widen inequalities within populations? In Babones S (Ed.). *Health, inequality and society.* Bristol: Policy Press, 2009.	Thank you.

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Institute of Health & Society, Newcastle University		3.11 and rec 11	There appears to be little clear evidence that children are more affected by food (or other) marketing than adults. Indeed the socio-economic patterning of susceptibility to advertising may be stronger. This has resulted in an unhealthy focus on the impact of TV advertising on children, to the exclusion of any attention on the impact on adults. The OfCom regulations on TV advertising of foods ('of particular appeal to children') are the result of this attention – and our recent national evaluation (as yet unpublished – research about to conclude) suggests that these may not have been as effective as intended – and may have had unintended consequences. We would be happy to share these results with NICE in due course (Please contact martin.white@ncl.ac.uk).	The view of the PDG was that it was appropriate to make recommendations on the degree to which children are exposed to advertising based on the aim of protecting children. This does not indicate that children are more or less likely to be influenced by advertising than adults.
Institute of Health & Society, Newcastle University		3.14-3.16 and recommendations	It may be important here to mention potential 'anti-health' forces operating at a community/societal level. For example, a significant (nearly 50% in some regions) proportion of tobacco consumed is now counterfeit or contraband – and we currently have no clear or effective national strategy to combat this illegal trade. There is also evidence to suggest that such products may be more carcinogenic than legally sold tobacco. This should also be reflected in the recommendations, since this is the 'next big challenge' in tobacco control.	Thank you. This is an important point which unfortunately is beyond the scope of the current guidance.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Institute of Health & Society, Newcastle University		3.29 and Rec 2	A significant proportion of the adult (and increasingly adolescent) population acquires much of its excess calorie intake from alcohol. Just as important as labelling foods would be to mandate labelling of all alcoholic drinks with both UNITS of alcohol *and* CALORIES per volume (ml). In addition, soft drinks, especially those sold in multi-packs or available in bars/clubs/pubs, where the nutritional labelling is only found on the outer packaging (i.e. case or box), need to have CALORIES on the label of each drink container (can or bottle).	The guidance (recommendation 6) now says: 'establish the Food Standards Agency's single, integrated, front-of-pack traffic light colour-coded system as the national standard for food and drink products sold in England.'
Institute of Health & Society, Newcastle University		4 – recommendations for policy – other key players	This list should include pubs, bars, clubs, restaurants etc., where alcohol and/or food are sold.	These groups are covered by 'caterers' and 'food and drink retailers'
Institute of Health & Society, Newcastle University		Rec 4, bullet point 4	I think this might be based on an incorrect assumption – or perhaps is just too sweeping a statement and needs qualifying to indicate what sorts of budget line ('value') foods need reformulating. See: Cooper S, Nelson M. 'Economy' line foods from four supermarkets and brand name equivalents: a comparison of their nutrient contents and costs. *Journal of Human Nutrition and Dietetics* 2003;16:339-347.	Thank you. This has been amended to say 'encourage manufacturers, caterers and producers to reduce substantially the amount of saturated fat in all food products'

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Institute of Health & Society, Newcastle University		Rec 8	Surely congestion charging in major towns and cities is worth a mention here? Also surely it is not just car parking offered as a benefit – local authorities could increase parking charges across the board as a disincentive to car use.	Thank you. Congestion charging is included in NICE PH guidance 8, referenced in recommendation 15.
Institute of Health & Society, Newcastle University		Rec 16	A key recommendation under this heading should be to ban the endorsement or sponsorship of activities, events or structures in all schools by food companies associated with high fat, salt or sugar products. Recent examples include Cadburys, Coca Cola and Walkers.	Recommendation 19 now says 'encourage venues frequented by children and young people and supported by public money to resist sponsorship or product placement from companies associated with foods high in fat, sugar or salt. (This includes fun parks and museums.)' And 'organisations in the public sector should avoid sponsorship from companies associated with foods high in fat, sugar or salt.'
Institute of Health & Society, Newcastle University		Rec 18	Free swimming should be extended to all children under 11 to ensure that all children learn to swim and develop habitual physical activity – by the age of 5 most children have not become sufficiently proficient to swim alone and that surely is the key to maintaining the benefit?	Thank you for this interesting suggestion.

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Medical Research Council Human Nutrition Research		General	*MRC Collaborative Centre for Human Nutrition Research (hereafter HNR) was established in 1998 to advance knowledge of the relationships between human nutrition and health by providing a national centre of excellence for the measurement and interpretation of biochemical, functional and dietary indicators of nutritional status and health. HNR conducts basic research in relevant areas, focusing on optimal nutritional status and nutritional vulnerability in relation to health, including the development of innovative methodologies. HNR responds to the strategic priorities of the wider scientific community by conducting research projects, within the scope of HNR's activities, in collaboration with, and on behalf of: other MRC establishments and groups, Government departments, industry, national and international agencies, universities, research foundations and charitable organisations. HNR also acts as an independent, authoritative source of scientific advice and information on nutrition and health in order to foster evidence-based nutrition policy and practice. In light of the work carried out at HNR and the expertise of our staff, our comments are confined primarily to the role of nutrition in securing good health for the whole population.*	Thank you
Medical Research Council Human Nutrition Research		2	It would be useful to include a physical (in)activity example in the 'downstream behaviours', such as TV viewing.	Thank you. This is not intended to be a comprehensive list of upstream and downstream factors but to be indicative only.

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Medical Research Council Human Nutrition Research		3.1	There is no overarching review on the efficacy of dietary interventions to decrease CVD risk. The two papers on salt and dietary fat have led to a focus on these aspects of diet with little or no mention of other nutrients. The absence of this evidence may be caused by the focus on evidence from trials "larger than the size of a UK PCT or from multifactorial population based prevention programmes". However it is essential to identify the data pertaining to efficacy of single dietary risk factors in order to inform the targets for population-wide interventions. The panel need to solicit a review analogous to Expert Report 1 on physical activity or the WHO Technical Report 916 on Diet, Nutrition and the Prevention of Chronic Diseases would be a good starting point.	thank you.
Medical Research Council Human Nutrition Research		3.13	The reference should be Brownell not Brownwell	This has been amended.

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Medical Research Council Human Nutrition Research		3.19	Obesity is identified as a key risk factor, but is not discussed further in this section, except tangentially in 3.29 in connection to labelling. Lifestyle interventions have been clearly shown to decrease diabetes incidence, a key CVD risk factor (eg. Diabetes Prevention Programme. NEJM. 2002: 346, 393-403 and Lindstrom et al (2002). Lancet; 346: 393-403) and the ongoing Look AHEAD trial is considering the impact of hard CVD outcomes. Again the absence of evidence may be attributable to the issues described for diet in section 3.1 above. There appears to be no specific consideration of high alcohol intake or the potential for population level interventions to reduce this risk.	Obesity was the topic of an earlier NICE guideline. Relevant evidence from this guideline was presented to the PDG. The guideline itself is referenced in recommendation 15. Similarly, high alcohol intake has been the subject of a separate NICE guidance, and this is included in section 7 'related NICE guidance'

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Medical Research Council Human Nutrition Research		3.23	The rationale for considering only dietary patterns and not individual nutrients is unclear – nutrient intervention studies provide clearer data on efficacy, although dietary pattern analysis may also be useful in developing population guidelines. Indeed para 3.22 notes the importance of considering single risk factors but focuses in immediately on salt, SFA, PUFA and trans fatty acids, without reviewing the wider literature on individual nutrients and CVD prevention. This section needs considerable revision (see also comments in 3.1). Some important review papers of individual nutrients include: Andersen et al NEJM 1995: 333, 276-282 (soy protein), Andersen et al J Am Coll Nutr 2000: 19, 3, 291S-299S (wholegrain), Anderson and Major. Proc Nutr Soc 2002: 88, Suppl 3, 263-271 (pulses and legumes), Hooper et al, BMJ doi:10.1136/bmj.38755.366331.2F (n-3 PUFA), de Bree et al AJCN 2007: 86, 610-17 (folic acid) and last year we provided a review to the FSA on the health effects of dietary fibre, including CVD outcomes and risk factors (Lennox et al 2008, confidential report to FSA). Please note, these references are not an exhaustive list and this issue warrants a formal review to identify the key nutrients for CVD prevention.	The PDG recognises that, although much of the evidence and therefore the recommendations relate to single nutrients, these have to be seen in the context of the whole diet. Dietary patterns that comply with current 'healthy' eating recommendations (based on fruit, vegetables and wholegrain foods) are more likely to provide profiles of nutrient intake associated with better cardiovascular health

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Medical Research Council Human Nutrition Research		3.23	More specifically, wholegrain, fish etc is associated with a lower risk of CVD – not a reduced risk – the evidence is from observational studies, not interventions. The de Lorgeril paper was a secondary prevention study and with approx 600 participants was well below the scale of "at least the size of one UK PCT' defined in the scope. We support including trials of this kind but the evidence needs to encompass all the nutrients and foods linked to CVD prevention (see comments on 3.1 and 3.19 also)	Thank you. This has been amended in the final guidance Thank you. This paper is referenced in the considerations section to provide additional context
Medical Research Council Human Nutrition Research		3.25	Two issues have been inappropriately merged here. Substituting low fat for high fat foods is a different intervention to changes in fat quality (eg. reducing SFA). No evidence is given in relation to the former, yet this is a key strategy for weight control and in wider CVD prevention. A reference should be included for the Japanese example of SFA reduction. Data from the FSA funded RISCK trial, available in abstract form (Jebb et al, (2008) Impact of the amount of type of fat and carbohydrate on insulin sensitivity in the RISCK study. Proc Nutr Soc 67: (0CE8) E313), paper under review, provides important data, from our explanatory study, of the impact on CVD risk of replacing SFA with MUFA or carbohydrate, including the effect of low GI foods (Sanders et al, (2008) Impact of the amount and type of fat and carbohydrate on serum lipids in the RISCK study Proc Nut Soc 67: (0CE8) E314).	Thank you. This has been amended.

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Medical Research Council Human Nutrition Research		3.26	The statement that salt reduction "can only be achieved by using a combination of voluntary and regulatory action" is not supported by the evidence of important and ongoing reductions in salt in the UK, achieved through voluntary measures, in the absence of regulation.	The final guidance acknowledges the progress that has been made through voluntary action. However, in the opinion of the PDG further progress will best be achieved by using a combination of voluntary and regulatory action (see 3.37).
Medical Research Council Human Nutrition Research		3.27	Salt reductions should be made "over time" if they are not to be detected by consumers. A reference should be included for the statement that reductions of 3g or 6g per day lead to a decrease in deaths from CVD, increase in QALYs and healthcare savings should also be included	Thank you. This reference has been added.
Medical Research Council Human Nutrition Research		3.29	It has also been argued that labelling calorie content of food in relation to hours of exercise necessary to expend similar calories is counter-productive, because of the inherent imbalance given that basal energy expenditure accounts for such a substantial proportion of total energy expenditure. Unless specific evidence is cited in relation to either argument, this section is too anecdotal to warrant inclusion in this document.	Thank you. This issue was discussed by the PDG. However, for the reasons identified (and those indicated here) the PDG did not feel it warrented a recommendation.
Medical Research Council Human Nutrition Research		3.31	The link between breast-feeding and a reduced risk of overweight is less clear-cut than often presented and reiterated here. In the UK and developed countries the association is strong, but it does not appear to persist in middle and low income countries suggesting that the association is strongly confounded by social status.	The PDG felt that there are some associations between breastfeeding and risk factors for CVD which had been raised by stakeholders. However, the evidence is currently insufficient to base a recommendation on it

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Medical Research Council Human Nutrition Research		3.32	It is surprising not to see evidence cited on the tracking of dietary habits (or physical activity) from childhood onwards, since this may be a more powerful contributor than the acute effects on CVD risk factors in childhood.	Thank you. A reference has been added to this consideration (now 3.29)
Medical Research Council Human Nutrition Research		3.38	The dietary guidance focuses on salt, trans fat and SFA/PUFA, with broad endorsement of the FSA Eatwell plate. However this does not consider the specific dietary factors associated with an increased risk of over-consumption and hence the risk of obesity. Excess weight gain is at least as important as the individual nutrients in the diet, certainly in the context of insulin sensitivity, a key CVD risk factor. Unlike physical activity, where the report specifically notes that interventions to promote activity are covered in other NICE guidance, there is no such statement for obesity and indeed population level interventions have received less attention than individual interventions.	Para 3.10 notes that smoking, physical activity and obesity have been covered by other NICE guidance. Recommendation 15 includes a reference to the NICE guideline on obesity. You may be interested to know that NCIE is currently working on guidance on four topics directly related to obesity (see http://www.nice.org.uk/guidance/phg/indevelopment/index.jsp;jsessionid=38E14429A58C4C6E3F24.0?textonly=false&d-16544-p=2)

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Medical Research Council Human Nutrition Research		4	"The policy recommendations are based on extensive and consistent evidence" seems a surprising statement given that the previous paragraph notes there is much less evidence on population approaches than individual interventions. Indeed, most of the evidence on which these recommendations are based appears to be from uncontested expert opinion rather than peer-reviewed publications. In many cases, evidence is inferred from other fields. This is not to diminish its importance, but it is neither 'extensive or consistent' in the usual definition of NICE evidence gathering procedures. Accordingly, while many of these recommendations may well be important elements of an integrated CVD prevention programme, few are based on direct evidence of effectiveness. As such, they lean towards more general policy guidance than explicit NICE recommendations which carry an expectation of robust and specific evidence of efficacy and effectiveness. Broader analysis of the dietary data as recommended previously may give rise to more targets for intervention which need to be incorporated into these recommendations.	These recommendations were developed by the PDG on the basis of an appraisal of the best available evidence. Use of expert opinion is a standard part of the development of NICE guidance.

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Medical Research Council Human Nutrition Research		4	There are virtually no recommendations pertaining to weight control, yet overweight and obesity are major contributors to CVD. This seems a great omission. At the very least, reference should be made to the population-level recommendations from previous NICE guidance on obesity. A number of the recommendations include reference to the use of economic levers to change the behaviour of individuals or institutions. We believe this is an important policy option, but at present there is little evidence of effective practical policy options on which to base specific recommendations.	Thank you. The NICE guideline on obesity is referenced in recommendation 15 in the final guidance.
Medical Research Council Human Nutrition Research		Rec 2	We have consistently supported the use of multiple traffic-light labelling as an important component of consumer information and choice and a pre-requisite for healthier purchasing habits. However, despite our enthusiasm, we have to note the lack of objective evidence that this does indeed shift purchases and hence the evidence base to adopt this on a mandatory basis through legislation is questionable. Indeed recent evidence questions the impact (Sacks G, Rayner M, Swinburn B. Health Promot Int. 2009 Oct 8. [Epub ahead of print]). Cont…	This recommendation (now number 6) aims to ensure the FSA front-of-pack labelling system is implemented rapidly. As noted in the introduction to the recommendations section, 'the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes'.
Medical Research Council Human Nutrition Research		Rec 2	The rationale for a further recommendation on specific labelling of high salt products is unclear, since this would seem to be implicit in 'traffic-light' front of pack labelling.	The final point about labelling of high salt products has been moved to recommendation 1, which deals with salt. It emphasises the use of the FSA system.

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Medical Research Council Human Nutrition Research		Rec 3	Whilst broadly supporting the recommendations as policy options for further consideration we are unaware of any specific evidence to support the detailed measures proposed to reduce salt.	Thank you. The PDG feel that the recommendations (now in recommendation 1) arise from consideration of the evidence.
Medical Research Council Human Nutrition Research		Rec 5	The conclusion that trans fats constitute a significant health hazard is not disputed but the relative importance of this at a UK level versus other nutrient targets has been extensively discussed and the SACN report on trans fat did not recommend specific further action, given the ongoing voluntary reductions. Whilst this does not argue against the benefits of further reductions it would be prudent to reconsider the wording of this section. It would be useful to present the evidence to justify the focus on trans fats rather than other nutrients.	This recommendation (now number 3) has been reworded, and the introduction amended to emphasise that the focus is to ensure the protection of groups of the population who may be consuming higher levels of trans fats than the population as a whole.
Medical Research Council Human Nutrition Research		Rec 6	Clearly public sector catering establishments contribute to the total dietary intake of the population and also have an important leadership role in driving up standards. But again, we are not aware of specific 'evidence' that initiatives such as the Healthy Food Mark are effective. Mandation would be expected to enhance compliance but evidence is first needed that it has a positive impact on dietary intake.	This recommendation (now number 10) has been amended to say 'assess the effectiveness of the 'Healthier food mark' pilot . If successful, develop a timetable to implement it on a permanent basis'

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Medical Research Council Human Nutrition Research		Rec 7	Evidence has not been provided on the contribution of fast-food outlets, take-aways etc to dietary intake. We support the principle of control, but fear the evidence is being overstated. For example, is it more important to restrict fast-food outlets than corner-shops/newsagents selling confectionery and soft drinks?	The PDG felt that it was important to use existing controls to address food outlets.
Medical Research Council Human Nutrition Research		Rec 21	This should include reference to NICE guidance on obesity.	Thank you. This guideline has been referenced in the recommendation (now 15)
Medical Research Council Human Nutrition Research		6	In summary, while supporting the public health ethos of these recommendations, as a research institute we are concerned at the fragility of the evidence base for some of the explicit recommendations. More than ever in the current economic climate, interventions need to be evidence-based and cost-effective. At the very least, there is a strong case that the impact of such recommendations must be carefully monitored and evaluated since it has the potential to inform action on other public health issues in the future.	Thank you. Recommendation 12 now addresses monitoring to 'ensure all appropriate data are available for monitoring and analysis to inform CVD prevention policy'. Recommendations 7 and 22 address the need for health impact assessment to address outcomes of policies.

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McNeil Nutritionals		3.9	**'Coronary heart disease risk reduction health claims' have been authorised in the European Union for plant stanols/sterols** As section 3.39 of the ***Guidance on the prevention of cardiovascular disease at the population level*** indicates, plant stanol and sterol esters have been proven to significantly and consistently reduce cholesterol in various populations (1;2). The efficacy of these ingredients has recently been acknowledged in positive opinions by the European Food Safety Authority which, in turn, led to the authorisation of the first 'disease risk reduction claims' in Europe (3, 4, 5). These authorative opinions confirm that plant stanol and sterol esters reduce cholesterol and that reducing cholesterol may reduce the risk of coronary heart disease (3, 4). Intake of 2g/day of plant stanols or sterols leads to significant reductions in LDL cholesterol, a proven risk factor for cardiovascular disease (2). Given the relationship between LDL cholesterol and coronary heart disease risk (6) these data demonstrate a proven diet based approach to reducing the burden of coronary heart disease risk in various populations.	Thank you

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McNeil Nutritionals		3.9	It has been shown that the potential burden of cardiovascular disease risk (CVD) can be reduced in the broader community when foods with these ingredients are consumed. The Doetinchem Cohort Study (7), examined the customary use and effects of phytosterol consumption over a five year period in 4505 subjects. The data indicate that, while the customary use of phytosterol enriched products was below recommended levels, usual increases in cholesterol levels were not observed in those reporting phytosterol intakes. A 0.26 mmol/L increase in serum cholesterol was observed in those participants not reporting intake of phytosterols. At a community level maintaining healthy cholesterol levels is important because it decreases the potential CVD burden. Based on these findings and with better compliance (intake of recommended intake levels) further benefits would be evident at community level. A follow up study (8) in this population indicated that actual cholesterol lowering as opposed to maintenance can be achieved. The group that consumed phytosterols had a lower cholesterol (0.24 mmol/L) compared to baseline values. The non-user group, as was observed in the previous study, had increased cholesterol levels.	Thank you

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McNeil Nutritionals		3.9	Using population data (the National Health Survey for England), the potential benefit of a more widespread approach to heart health with these ingredients has been simulated (9). The CVD levels of the populations were estimated using the Framingham equation applied to the data from the National Health Survey for England. The population simulated was one that was free of atherosclerosis and diabetes. Modeling this population free of high risk individuals provides a better sense of how a community would benefit from a public health programme based on these ingredients. The models built were successful in replicating the epidemiology data that indicates the benefits of universally lower cholesterol levels, that is lower CVD risk. Models of universal use of phytosterols (target goal of total cholesterol being reduced 0.5 mmol/L) resulted in an 11.8 percent reduction in CVD event s. While there are limitations to the methodology, the model provides an insight into how dietary approaches can be leveraged with potentially large benefits. Cont…	Thank you.

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McNeil Nutritionals		3.9	Foods containing plant stanols/sterols are widely and readily available in stores through-out the UK, both as branded and own-label offerings. They are also available in a wide variety of food formats, such as, dairy products, spreads, soya drinks which facilitate their inclusion into the diet.	Thank you. Para 3.74 notes that 'daily consumption of products containing plant sterols and stanols may reduce blood cholesterol by about 10% – and so may reduce CVD mortality substantially.' However, the PDG felt it was not clear how a recommendation on their use might impact on inequalities in health and were unwilling to make a recommendation for action. The final guidance contains a research recommendation on this topic.
McNeil Nutritionals		4 - Rec 2	**Recommendation 2: Should recognise the critical importance of health claims particularly those related to foods that could help reduce the risk of CVD.** In the context of product labels, that are used for communicating messages to consumers, the new EC authorised health claims, such as the disease risk reduction claims for plant stanols and sterols are important in heart health programmes. The importance of substantiated health claims that impact on CHD risk factors should be recognised as these encourage manufacturers towards developing health enhancing foods and facilitate consumer efforts towards choosing heart healthy diets.	Thank you. The approval of health claims is a matter for the EC. The claim for plant stanol esters was added to the list of permitted claims in October 2009 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2009:277:0003:0012:EN:PDF)

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McNeil Nutritionals		Recommendation 10	**Recommendation 10: We endorse engagement of industry as partners by local and national groups who lead public health initiatives in the planning and execution of such activities** Engagement of industry as partners in initiatives should be recommended. Local and national partnerships that engage government, academics and industry are certain to have greater impact then when the partners act in isolation. This should certainly be considered as part of recommendation 19-24. Industry has much to offer in regards to the activities listed in these recommendations.	Thank you.
McNeil Nutritionals		Recommendation 15	**Recommendation 15: Should recognise the impact of foods that meet health claim requirements could make in national food service programmes.** In addition, to foods low in salt and saturated fats, recognition should be paid to ingredients/foods that have obtained an authorised health claim, such as, phytostanols/sterols that are proven to reduce cholesterol, a key risk factor in the development of coronary heart disease.	Thank you. As indicated above, the PDG did not feel able to make an action recommendation, however a research recommendation about stanols/sterols has been included in the final guidance.

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McNeil Nutritionals		References	1. Miettinen TA, Puska P, Gylling H, Vanhanen H, Vartiainen E. Reduction of serum cholesterol with sitostanol-ester margarine in a mildly hypercholesterolemic population. N Engl J Med 1995;333:1308-12. 2. Law MR. Plant sterol and stanol margarines and health. West J Med 2000;173:43-7. 3. EFSA. Plant stanol esters and blood cholesterol. Scientific substantiation of a health claim related to plant stanol esters and lower/reduced blood cholesterol and reduced risk of (coronary) heart disease pursuant to Article 14 of Regulation (EC) No 1924/2006. *The EFSA J.*, 2008, 852, 1-13. 4. EFSA. Scientific Opinion of the Panel on Dietetic Products Nutrition and Allergies on a request from Unilever PLC/NV on Plant Sterols and lower/reduced blood cholesterol, reduced the risk of (coronary) heart disease. *The EFSA J., 2008,* 781, 1-12.	Thank you

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McNeil Nutritionals		References	5. COMMISSION REGULATION (EC) No 983. on the authorisation and refusal of authorisation of certain health claims made on food and referring to the reduction of disease risk and to children's development and health. Official J. European Union 2009, No 983, 3-10. 6. Grundy S, Cleeman J, rz C et al. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines. J Am Coll Cardiol 2004;44:720-32. 7. Wolfs M, de JN, Ocke MC, Verhagen H, Monique Verschuren WM. Effectiveness of customary use of phytosterol/-stanol enriched margarines on blood cholesterol lowering. Food Chem Toxicol 2006;44:1682-8. 8. de JN, Zuur A, Wolfs MC, Wendel-Vos GC, van Raaij JM, Schuit AJ. Exposure and effectiveness of phytosterol/-stanol-enriched margarines. Eur J Clin Nutr 2007;61:1407-15.	Thank you
McNeil Nutritionals		References	9. Reynolds TM, Mardani A, Twomey PJ, Wierzbickid AS. Targeted versus global approaches to the management of hypercholesterolaemia. J R Soc Promot Health 2008;128:248-54.	Thank you.

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National Farmers' Union		General	We understand that NICE has been developing and reviewing this guidance document for 18 months. The NFU had not been contacted at any point during this process and did not receive any information from NICE about this consultation. This is difficult to understand considering the NFU's position as the leading trade association for farmers and growers, and considering the direct relevance to our members in terms of the recommendations made about the Common Agricultural Policy and proposals about differential pricing and reformulation. It is inappropriate that recommendations aimed at the farming sector are produced without this sector being consulted as a major stakeholder. The 'phased process' set out on pg 3 of the workshop notes includes several 'consultation with stakeholders' steps. The NFU and several other food industry stakeholders were not consulted. The 'farming sector' is listed as a key player on page 24.	Thank you. This guidance followed the processes outlined for the production of NICE public health programme guidance. National organisations were invited and encouraged to register as stakeholders at any stage in the process. As a standard part of the process the draft guidance was issued for consultation between 14 September and 12 October 2009. As part of the usual process, an organisation was contracted to run 'fieldwork' meetings with relevant organisations. In this instance these were carried out by Greenstreet Berman. As part of this process, the NFU was contacted and invited to attend.

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National Farmers' Union		General	Due to only finding out about the consultation indirectly, it was too short notice for the NFU to send anyone to the workshops. However, our contacts amongst other stakeholders have said there was little support for the draft guidance. We very much hope that this is taken into account and that NICE seriously reconsiders the value of publishing the guidance in anything like its current form.	Thank you. All the stakeholder comments and fieldwork findings have been considered by the PDG in developing the final guidance.
National Farmers' Union		General	To compare the food industry to the tobacco industry (top pg 14) is insulting.	Thank you. This quote from a published paper has been amended. Para 3.53 now says 'the PDG believes that more could be done to assist those sectors which have, for a variety of reasons, been unable or unwilling to take positive action. Such action would not only benefit the population, but would also help provide a 'level playing field', where all businesses work to the same standard. Brownell and Warner (2009) state: 'there is an opportunity if the industry chooses to seize it – an opportunity to talk about the moral high ground and to occupy it''
National Farmers' Union		General	We are not aware of any evidence that the CAP/agricultural policy and practice has a powerful impact on diet (bottom page 21) and this is not presented in the draft document. The 'extensive and consistent evidence that these changes would be most effective and cost effective' (bottom pg 22) is not referenced.	Thank you. Evidence is presented in the expert papers.

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National Farmers' Union		Recommendation 1	This appears to be largely based on campaigns linking the CAP to poor diets over the past two decades or so. They are based on a profound misunderstanding of the mechanisms of the CAP, both in its original form and current decoupled system. Previously support was for production of, most notably in this context, red meat and dairy, but not for fruit, vegetables and white meat. This guaranteed higher prices for the producer and therefore for the consumer. If anything, this would have discouraged consumption of red meat and dairy and encouraged that of the other products that were exposed to market forces. Now that support has been decoupled from production, there is no policy pressure to produce one product more than another. It is therefore no longer appropriate to make any link between agricultural support and dietary health policy.	The PDG believes that agricultural policy can have a significant effect on the health of the population. This recommendation (now number 8) is intended to ensure that public health is included as one of the explicit 'public goods' that the CAP supports. This would help ensure CAP spending takes adequate account of its potential impact on CVD risk factors and is used in a way that optimises the public health outcomes.

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National Farmers' Union		Recommendation 1	In the context of decoupling and the direction of CAP reform, and the lengthy cycles of investment and production in agriculture and horticulture, it would not be feasible to use the CAP to introduce specific incentives to distort production for specific products as suggested. It is unclear from the recommendations how healthy eating guidelines would be included in the CAP and therefore applied to the whole of the EU. However, any change to all the legislation associated with CAP would take many many years. Any subsequent impact on production and then on consumption would take even longer. These timescales are not consistent with the desired speed of change described in the document.	Thank you. The document presents recommendations that will support both rapid and longer term benefits.
National Farmers' Union		Recommendation 1	The European Commission, through DG Sanco, is driving the 'Health in All Policies' initiative. The EU School Milk Scheme has recently been relaunched to include a larger range of healthy dairy products, beyond just drinking milk. There has been a School Fruit Scheme for many years in England and there is a new EU school fruit scheme. There is a Common Marketing Organisation (CMO) for fruit and vegetables, funded by Pillar 1, one aim of which is to promote consumption. Pillar 2 promotes physical activity through support for public access initiatives, many on the edge of towns and cities.	Thank you.

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National Farmers' Union		Recommendation 1	There are physiological reasons for the fat content in milk, which limit the degree to which a lower fat primary product can be made. There could also be welfare implications related to reductions in fat content.	Thank you.
National Farmers' Union		Recommendation 1	Processors calculate the price of milk based on butter fat content according to the specifications they need to produce the range of dairy products on the market.	Thank you.
National Farmers' Union		Recommendation 1	The livestock and meat industries have altered carcass composition over many years. It has reached the point at which the market and processing needs cannot be met with any further reductions in fat content.	Thank you.
National Farmers' Union		Recommendations 2, 3, 4, 5, 10	The food industry has made commitments under the EU Platform on Obesity and Health, through such activities as new product development. NPD and innovations in the food industry move much more quickly than legislation, especially European legislation, which would be needed to put requirements on formulation. It is not feasible to set EU targets e.g. for salt. Fiscal measures do not encourage NPD.	Thank you. These are now recommendations 6, 1, 2, 3 and 5. The final guidance acknowledges the progress made by industry and others.

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National Farmers' Union		Recommendations 2, 3, 4, 5, 10	The food industry has already taken significant action across a wide range of foods to reduce salt, saturated fat, trans fat and total fat.	The final guidance acknowledges the progress made by industry and others
National Farmers' Union		Recommendations 2	We do not support choice editing as a legitimate and appropriate way to achieve healthy diets at a population level.	Thank you. This is now recommendation 6. This recommendation aims to ensure that the Food Standards Agency's integrated front-of-pack labelling system is rapidly implemented as the national standard for food and drink products sold in England, and to ensure labelling regulations in England are not adversely influenced by EU regulation.
National Farmers' Union		Recommendations 2	There are a wide range of factors that contribute to the price of food, not simply taxation.	Agreed.
National Farmers' Union		Recommendation 2	The FSA is currently developing its policy on traffic light nutrition labelling and have been working on this for a number of years. NICE should leave this issue to the FSA.	Thank you.

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National Heart Forum		General	Although this NICE guidance is aimed specifically at the prevention of cardiovascular disease, the NHF believe that it would be worth noting within this guidance that there will also be benefits for other avoidable chronic diseases (such as some cancers, diabetes, and stroke) that result from strategies and interventions addressing CVD. These other avoidable chronic diseases share common risk factors to CVD and will therefore likely benefit from the suggested recommendations outlined throughout this draft guidance. There could be a greater focus on health inequalities within this guidance, particularly as the social determinants of health will become even more relevant in the current economic climate.	Thank you. This is now addressed in para 3.73. The role of a population approach on health inequalities is addressed in 3.17-19.
National Heart Forum		General	The NHF would like to see greater mention of the links between health, climate change and sustainable development. Many of the key measures needed to prevent dangerous climate change are the same as the key measures needed to prevent many avoidable chronic diseases. As a society, it is important that we understand and appreciate the co-benefits from measures such as active transport, improving the built environment, local food sourcing, and healthy and sustainable agriculture among others. We also think that there is a need for more work on the research recommendations, especially upstream policy oriented intervention research.	Thank you. These are addressed in paras 3.75 and 76. It is usual practice for the draft guidance not to contain research recommendations. These are included in the final guidance.

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National Heart Forum		Rec 1 - common agricultural policy	The common agricultural policy (CAP) is the overarching framework used by European Union member countries to form their own agricultural policies. The burden of diet related disease has grown considerably since CAP was first implemented. CAP reform offers a significant opportunity to address this burden of disease. Recent CAP reform that has shifted money from the first to the second pillar, re-calibrated the first pillar (reducing coupled subsidies and market intervention while expanding the Single Farm Payment (decode SFP) and public goods payments), and focused the second pillar more strongly on public goods (through the so-called 'new challenges'). European money should promote European public goods, and nothing else. Under current EU law Public Health is not considered to be a Public Good.	Thank you. This recommendation (now number 8) includes 'negotiate at EU and national level to ensure the CAP takes account of public health issues. Health benefits should be an explicit, legitimate outcome of CAP spending. This can be achieved through formal recognition of health as a 'public good''

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National Heart Forum		Rec 1 - common agricultural policy	*What action could be taken?* • Negotiate to amend the common agricultural policy (CAP) to ensure it takes account of public health issues. Public health to be adopted as a public good. • Payments under Pillar One should be progressively phased out so that all payments fall under Pillar Two. This will allow us to better protect our health, climate and the environment, improve and stimulate economic growth. • Ensure future financial rewards under Pillar two rewards the production of foods of higher nutritional quality such as fruit, vegetables, whole grains and leaner meats. • Negotiate to ensure the European Commission's (EC) impact assessment procedure (part of its strategic planning and programming cycle) takes the effect on cardiovascular health and wider public health matters into account	Thank you. This recommendation (now number 8) has been amended to address these points.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 1 - common agricultural policy	The two recommendations below should be moved to Saturated Fat as they do not apply to future CAP structure: • Ensure fiscal incentives and disincentives for industry support the production of low saturated, as opposed to full-fat, dairy products and fruit, vegetables and cereals for human consumption. Ensure reduced-fat dairy products are cheaper than their full-fat equivalents	These points have been amended and moved to recommendation 2 (saturated fats)
National Heart Forum		Rec 2 - product labelling and marketing	The NHF strongly support the recommendation to implement without delay the integrated front of pack nutritional labelling scheme developed by the FSA. The scheme combining traffic light colour-coding, text to indicate high, medium and low levels of nutrients and GDA percentages has proven to be most useful to all consumers when checking - at a glance – levels of fat, saturates, sugars and salt in food and drink products. Legislative options should be explored to ensure that a clear consumer tested messaging scheme is applied across all brands and all products.	Thank you. This recommendation is now number 6.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 2 - product labelling and marketing	The NHF do not support the recommendation to restrict advertising for all products that carry red or amber traffic light nutritional labels. However, nutrient profiling should be developed and extended to underpin restrictions on food and drink products marketed and promoted to children in non-broadcast media, and which complement existing TV advertising restrictions.	Thank you. The proposed restriction on advertising has been removed. Recommendation 4 now includes 'ensure restrictions for non-broadcast media on advertising, marketing and promotion of food and drink high in fat, salt or sugar are underpinned by the Food Standards Agency nutrient profiling system'
National Heart Forum		Rec 2 - product labelling and marketing	All products labelled 'red' for salt should be consumed infrequently and/or in small amounts. The addition of an additional warning label on some products may confuse consumers if it did not appear on all products that score a 'red' for salt. We recommend that instead there should be clear messaging – led by the FSA - about healthy eating patterns to reinforce the integrated front of pack nutritional signpost.	Recommendation 1 now includes a bullet point that products high in salt should be labelled using the FSA approved traffic light system.
National Heart Forum		Rec 3 - salt	The NHF agree that population salt levels should be reduced to a maximum of 6g per day (for adults) and preferably move towards a lower level of 3g per day in the long term. Children's intakes should be significantly lower still according to their age, as agreed by SACN.	Thank you. Recommendation 1 suggests a longer term target of 3g per day by 2025

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National Heart Forum		Rec 3 - salt	The NHF recognize that current voluntary efforts to reduce salt in commonly consumed foods have been successful in many categories. The legislative option should be kept open in the event that in future, some categories or manufacturers refuse to cooperate with the voluntary reductions, and impede this important public health measure. We agree that all food products should be under consideration, with priority given to foods which are the major contributors of salt to the diet such as bread, soups, sauces, ready meals and processed foods.	Thank you. The recommendation (1) now includes further acknowledgement of the progress that has been achieved by voluntary measures.
National Heart Forum		Rec 3 - salt	The NHF support the recommendation to agree EU salt reduction targets and to establish robust monitoring of salt levels in commonly consumed foods.	The final guidance supports the FSA in promoting and taking a lead in the development of EU-wide targets
National Heart Forum		Rec 3 - salt	The NHF support the recommendation to set a clear timetable for salt reduction targets with a deadline for the introduction of mandatory regulation if progress is not achieved by voluntary means.	Thank you. As noted in the introduction to the recommendations, the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes.

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National Heart Forum		Rec 3 - salt	In view of the greater likely effectiveness of reformulation strategies on reducing overall salt intakes, we see these as taking priority over consideration of fiscal incentives and disincentives to affect prices.	Thank you.
National Heart Forum		Rec 3 - salt	While in principle it makes sense to tax culinary salt to encourage people to add less salt to food, the price effect of VAT at standard rate is unlikely to have a significant effect.	Thank you. This has been deleted.
National Heart Forum		Rec 4 - saturated fats	The NHF agree that fiscal levers should be properly explored and modelled to see what effects they may have on both healthy and less healthy components of the diet. It is particularly important to understand what unintended effects may arise (in relation to other nutrients such as salt and added sugar, if a tax is applied to saturated fat for example).	The recommendation now says 'create the conditions whereby products containing lower levels of saturated fat are sold more cheaply than high saturated fat products. Consider legislation and fiscal levers if necessary'. It is important to identify unintended consequences of policies, and this is emphasised by recommendation 7.
National Heart Forum		Rec 4 - saturated fats	Proposals to apply or remove VAT are worth consideration, in view of the fact that VAT is not currently rationally applied in terms of nutrition. However, the potential for VAT manipulation is constrained by EU rules and is likely to be limited at a Member State level.	The specific reference to VAT in this recommendation (now 2) has been removed.

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National Heart Forum		Rec 4 - saturated fats	Reformulation efforts to reduce levels of saturated fat and remove artificial trans fats should be pursued across all food categories and ranges.	Thank you. This has been extended to all food products.
National Heart Forum		Rec 4 - saturated fats	The NHF believes that there is a need to add professional and public education campaigns as a sub-recommendation to this section.	Thank you
National Heart Forum		Rec 5 - trans fats	The NHF is supportive of recommendation 5 'to eliminate them [trans fats] altogether from the national diet'. There are serious concerns about the significant risk of industrially produced TFAs (IPTFAs). We strongly believe that the public health goal ought to be elimination of IPTFAs from the food supply, including from foods eaten outside the home.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 5 - trans fats	*What actions could be taken?* • EU wide ban Industrially produced trans fats (IPTFAs) are a global concern and different countries have adopted a wide range of responses. Most initiatives are voluntary with regulatory action limited to Denmark, New York City, Switzerland and since September 2009 Austria. Considering the current dietary ill-health and levels of coronary heart disease (CHD) in the UK, the NHF believes that the ban of IPTFAs is of high priority for the UK and should be implemented as quickly as possible. Therefore we urge the UK government to follow Denmark and Austria's lead in banning IPTFAs as soon as possible. We appreciate that consumer and industry interests need to be harmonised across the EU in the long term, but UK wide action on the issue is permissible because similar action in Demark was eventually supported by the European Commission.	This bullet point (recommendation 3) has been amended to advocate for a maximum level of 2%IPTFA in fats and oils used in food manufacture and cooking. This was felt to be a pragmatic, monitorable position.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 5 - trans fats	• Less than 0.5% of daily energy value for all groups The NHF strongly agrees with this action as there is no known safe level of consumption of TFAs. Taking this precautionary approach of eliminating industrially produced TFAs (IPTFAs) from the food supply, including from foods eaten outside the home will ensure that all population groups consume less than 0.5% IPTFAs of daily dietary energy. This would also be in line with current international recommendations such as the 2009 WHO scientific update for example. In addition, this precautionary approach would also reduce health inequalities as some subgroups of the population including children can eat up to 12% of dietary energy from IPTFAs (Lloyd S, Madelin T, Caraher M. Chicken, Chips and Pizza: fast food outlets in Tower Hamlets unpublished report. 2009).	The aim of this recommendation was to ensure that all groups are protected from the harmful effects of IPTFAs

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National Heart Forum		Rec 5 - trans fats	*What actions could be taken? (continued)* • Replacement of trans fatty acids The NHF is supportive of this action and believes that legislation is necessary to ensure that IPTFAs are being replaced by 'healthy' vegetable oils high in polyunsaturated and monounsaturated fatty acids. We believe that this legislation should be seen as supportive of the already successful saturated fat reduction programme run by the Food Standard Agency (FSA). While we acknowledge the currently voluntary measures by the industry to reduce IPTFA levels mainly in processed foods, we believe legislation is needed to ensure that IPTFAs are not replaced by unhealthy saturated fats potentially negating the efforts of the FSA saturated fat programme. Furthermore, legislating to eliminate IPTFAs is in line with the national objective of lowering the UK saturated fat intake and reduces health inequalities.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 5 - trans fats	• Independent monitoring of trans fat levels The NHF agrees that independent monitoring of trans fat levels in processed and take-away food is necessary to identify the consumption of all population groups and to verify industry declarations. We believe that independent monitoring should fall into the remit of the Trading Standards Office and/or Environmental Health officers. As consumption levels within the different population groups and subgroups is estimated to vary significantly due to varying eating patterns, it is important not to rely on an average population consumption figure.	The recommendation now says 'establish guidelines for local authorities to monitor independently IPTFA levels in the restaurant, fast-food and home food trades using existing statutory powers'
National Heart Forum		Rec 6 - catering guidelines	There is much that can be done to ensure that food supplied in public-funded settings is nutritious and affordable. Priority should be given to setting standards for public procurement (see recommendation 15) and mandatory nutritional standards where there is a duty of care, for example the nutrient-based standards for school food which are supported by the School Food Trust.	The recommendation (10) aims to ensure that food in publically funded settings meet FSA-approved guidelines. Additional recommendations (19 and 20) also address food provided in similar settings

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National Heart Forum		Rec 6 - catering guidelines	The effectiveness of the Healthy Food Mark in enshrining health and sustainability criteria within public sector catering should be carefully monitored.	As the Healthier food mark pilot evaluation has not been published, the guidance recommends assessing its effectiveness and developing a timetable to implement if successful.
National Heart Forum		Rec 7 - take-aways and other food outlets	The NHF endorses the recommendations outlined in section 7. There is evidence to support that urban planning has a role in creating and managing the built environments we live in. It therefore has an influence on our health and our ability to maintain good health. Planning policies and Development Plan Document (DPD) policies provide good examples of how policies outside of the health sector have both a direct and indirect impact on the determinants of health for communities and populations. Good policy guidance and urban planning can make healthy choices easier, encourage active and healthy living, and help address health inequalities within a community.	Thank you. This recommendation is now number 11.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec **8** - active travel	Promotion and uptake of active travel requires the provision of adequate and easily accessible infrastructure. It would be worthwhile to incorporate in this section some of the recommendations included in section 18 relating to physical activity. This would include actions that help to shape the built environment in ways that make active travel more desirable and easier to do, for all people, such as: Investing in (and maintaining) larger and better footpaths, which allow for mixed users (e.g. walkers, runners, people with push-chairs or prams, people requiring mobility assistance, and people with disabilities). Prioritising the needs of pedestrians and cyclists over motorists when developing or retrofitting streets and public spaces.	Recommendation 9 now encourages support of physically active travel. Practice recommendation 21 includes 'ensure the physical environment encourages people to be physically active' and references NICE public health guidance 8 which includes recommendations on these areas..
National Heart Forum		Rec **8** - active travel	Encouraging local authorities to reduce the default speed limit in built-up areas to 20 mph. Research has shown that traffic and the speed at which vehicles travel is the main reported barrier to active travel. Lower traffic speeds also leads to increased perceptions of safety, another important aspect for determining whether people decide to switch to active travel modes. Transportation infrastructure investments that support physical activity can improve local travel options and provide increased opportunities for recreation and physical activity.	NICE PH guidance 8 (referenced in recommendation 21) recommends introducing traffic calming schemes to restrict vehicle speed. You may be interested to hear that NICE will be producing guidance on road design to reduce injuries in children and young people later this year.

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National Heart Forum		Rec **9** - health impact assessment	Sustainable economic development and long-term economic growth are only possible if both environmental and health impacts are considered in all government policies. Health impact assessments (HIA) tend to be under-utilised and their results overlooked, when compared with environmental impact assessments. Health impact assessments can help policy makers meet the goal of health in all policies, and should be mandatory for all policy and planning. Monitoring the outcomes of policy following the assessment should also take place in order to identify if any follow-up action or amendments are required. The NHF recommends that legislation similar to that for strategic environmental assessment (SEA) and environmental impact assessment (EIA) should be passed for health impact assessment. The directives for SEA and EIA give legal force to the EU treaty at member state level obligation to protect the environment, and could serve as a model to create a legal obligation to carry out a health impact assessment.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 10 - commercial interests	The WHO Framework Convention on Tobacco Control offers many lessons in protecting public health at the global level and in tackling trans-border trade and marketing. Key among these - protection of public health policies with respect to nutrition from commercial and other vested interests of the food and drink industry.	Thank you. This recommendation (5) now says 'encourage best practice for all meetings, including lobbying, between the food and drink industry and government (and government agencies). This includes full disclosure of interests by all parties. It also involves a requirement that information provided by the food and drink, catering and agriculture industries is available for the general public and is auditable'
National Heart Forum		Rec 10 - commercial interests	We strongly support the development of a public health information system along the lines of the tobacco control 'Globalink' system which is free of commercial involvement.	This is now the subject of a separate recommendation (12) which addresses monitoring.
National Heart Forum		Rec 10 - commercial interests	The NHF support the routine declaration of meetings of lobbyists and representatives of the food and drink industry with government, rather than reliance on Freedom of Information requests. The Food Standards Agency sets a good example in declaring meetings held between its officials and the industry and other stakeholders.	Thank you. See response above.
National Heart Forum		Rec 10 - commercial interests	The NHF agree that it is in the public interest to ensure that disclosure rules are rigorously enforced including declarations of interests. Important public health initiatives should not be undermined by conflicts of interests.	Thank you.

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National Heart Forum		Rec 11 - children	We strongly support the need to protect children from all forms of marketing for food and drink products in all media. The 'Sydney Principles' are a good basis for developing principle-based regulation that respect children's right to a healthy start in life.	Thank you. This is now recommendation 4.
National Heart Forum		Rec 11 - children	The ban on food and drink advertising to children on TV should be extended to all non-broadcast media, and should be more effectively applied to ensure that it is children's exposure to promotions rather than notions of 'targetting' that determine how the rules are framed. This may necessitate the development of new regulatory arrangements, particularly where self-regulation has proved ineffective in reducing children's exposure to food and drink promotion, or where marketing methods fall outside any current regulatory regime.	The recommendation is for restrictions on advertising scheduling up to 9pm and for the development of equivalent standards for non-broadcast media.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 12 - take-aways and other food outlets	Using existing powers to limit the number of take-aways in a given area should lead to reduced access and consumption of the types of foods sold at take-aways (which contain high levels of trans-fat, saturated fat, salt, and sugar); this will contribute towards achieving a decline in overweight and obesity levels, and reduce the risk factors associated with cardiovascular disease. In addition to the above recommendation included in section 12, we also suggest including a recommendation that specifically targets and encourages existing take-aways to improve the nutritional value of their meals for example, by using healthier frying methods, and cutting salt and sugar. Nutritional labelling available at the point of sale is another important measure to include as it enables consumers to make informed choices.	Thank you. This is now recommendation 11. Recommendations 23 and 24 address improving the nutritional quality of food provided by take awars and other food outlets, and health and nutrition training for catering managers.
National Heart Forum		Rec 13 - health impact assess ment	HIA training should be developed and implemented in order to help local authorities and planners make a seamless transition into routinely incorporating health into the planning process. This training should not be limited to only a one-off training session. If health is to be incorporated at various stages of the planning process, the delivery of relevant HIA training should also reflect this. Evaluation and follow-up of such training would also be necessary.	This is now addressed in recommendation 22. This includes the identification of training and support needs of staff involved in carrying out assessments.

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National Heart Forum		Rec 14 - training	In addition to training in hygiene and nutrition, caterers should be provided with information and advice about better frying practices and frying oil quality standards to reduce the risk of introducing in the food supply trans fats, acrylamides and other toxic compounds produced during deep fat frying.	This is addressed in recommendations 23 and 24.
National Heart Forum		Rec 14 - training	The NHF support the need for standards in public sector food procurement. In addition to the criteria listed, we recommend that meals should only use fish that is certified from sustainable fisheries to help ensure that this nutritious food source is available to future generations.	While this is an important issue it was felt that it was beyond the scope of the guidance to make specific recommendations.
National Heart Forum		Rec 14 - children and young people	In addition to the actions listed, there should be action by the government to protect children and young people from inappropriate food and drink brand sponsorship and promotions in schools and community settings.	Recommendation 19 says 'encourage venues frequented by children and young people and supported by public money to resist sponsorship or product placement from companies associated with foods high in fat, sugar or salt. (This includes fun parks and museums.)' and 'organisations in the public sector should avoid sponsorship from companies associated with foods high in fat, sugar or salt'

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National Heart Forum		Rec 17 - local and regional policy	The NHF is strongly in support of the actions outlined in recommendation 17 towards the promotion of heart health and other cause related avoidable chronic conditions: to ensure there is funding to support physically active travel and to give people in disadvantaged areas access to affordable fruit and vegetables. Calorie-for-calorie, unhealthy food (typically foods high in fat, sugar and/or salt) costs less than healthy products such as fruits and vegetables. Since unhealthy food is cheaper, low income families are often under cost pressure to choose items that can lead to health problems over time. Enabling greater access to healthy food options such as affordable fruit and vegetables can help to reduce the health outcome disparities within disadvantaged areas. Incidental activity through active travel provides an opportunity for incorporating physical activity into the routine of everyday living. Funding to support physically active travel would help to make active travel modes more attractive and more easily accessible for all people. Targeting funding for active travel will also help address and potentially change the current obesogenic environment that fosters sedentary lifestyle choices. Cont…	Recommendation 21 incorporates the bullet on aligning 'planning gain' agreements to support physical activity. However, the PDG felt that there was a lack of evidence to support the use of 'planning gain' to give people in disadvantaged areas access to fruit and vegetables. This point has therefore been deleted.

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National Heart Forum		Rec 17 - local and regional policy	A reduction in the default traffic speed limit to 20mph would also have the potential to provide more opportunities for active travel, as it would help to create a more inviting and walkable environment, which provides physical activity opportunities for everyone. The NHF also recommends that the three determining test questions operated by the Department of Health are applied to all local and regional policies. Policy makers should answer these three screening questions relating to the impact on health services, health determinants, and lifestyle related risk factors, to determine whether a full health impact assessment is required.	The recommendation (now 21) includes reference to the NICE guidance PH8. As indicated, this supports the use of traffic calming to reduce vehicle speeds. Currently the evidence relating to widespread 20mph zones (for instance in Portsmout) have not looked at the influence on physical activity.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 18 - physical activity	The NHF strongly supports the recommendation that local authorities should allocate part of the budget for road building to promote walking, cycling and other forms of travel that involves physical activity. Prioritising the needs of pedestrians and cyclists over motorists when developing or redeveloping streets is essential if active travel modes are to be a practical option for people. However appropriate and adequate infrastructure also needs to be in place in order to facilitate and cope with the increase in numbers of those people travelling by active modes. For example, alongside the promotion of cycling there also should be greater funding allocation towards storage areas for bikes. Recommendations should also promote and support changes to the built environment that would encourage increased physical activity for people of all ages and abilities, such as: wider footpaths, the inclusion of separate pathways, pedestrianized / naked streets, slower speed limits, greater emphasis on green infrastructure, and the incorporation of artwork along paths, streets and public places.	As indicated above, this recommendation (now 21) refers to NICE guidance PH8 which makes recommendations along many of these lines.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
National Heart Forum		Rec 18 - physical activity	There is a clear omission of play within this section. It is important that children and young people have regular access and opportunities for unstructured play. Improved and better health for children can be achieved through play. Local authorities should ensure that these opportunities for physical activity exist, and that play areas are inclusive and accessible.	The recommendation (now 21) includes addressing the need for children and young people to be physically active, including provision of play spaces. This includes reference to NICE guidance 17 on promoting physical activity in children and young people
Nestlé UK Ltd		General	Nestlé UK welcomes the opportunity to respond to the NICE Public Health Programme Guidance – Cardiovascular Disease.	Thank you.
Nestlé UK Ltd		General	Nestlé UK Nutritionist, attended the NICE workshop (19/10/09, Regents Park College) regarding this Guidance and supports the comments made (from a broad perspective) within the workshop as represented by the minutes prepared by Greenstreet Berman.	
Nestlé UK Ltd		General	Nestlé UK would like to question the remit of NICE. NestléUK understands that the primary role of NICE is to provide guidelines for Health Care Professionals. Nestlé UK believes that these guidelines are outside the scope of NICE. In particular, Nestlé UK would like to question the role of NICE with regards to setting guidelines incorporating European targets and guidelines where fiscal policies are recommended.	In 2005 NICE acquired a public health role and the remit was extended beyond the provision of guidelines to health care professionals. As indicated in the introduction to the policy recommendations, these provide the outline for national framework for reducing CVD at population level. The guidance notes that 'the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes.'

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Nestlé UK Ltd		General	Nestlé UK would like to challenge the role of NICE in setting such broad ranging public health guidelines. NICE state that part of its role is "*to provide clear guidance where there is uncertainty. We don't produce guidance on every health topic. We are asked by the Department of Health to look at areas where there is confusion or uncertainty among healthcare professionals about the value of a drug, device or treatment. We also look at ways to promote and encourage good health in areas where there isn't already clear, nationally-agreed guidance".* Nestlé UK believe that for many of the areas covered by the guidance, there is already clear nationally, agreed UK guidance as well as comprehensive European legislation that already exists or that is being prepared. We have detailed some of the guidelines below and given specific information where we believe that the guidelines go against, or do not incorporate national and European initiatives that are already in existence.	Noted. Topics addressed by NICE are referred to the organisation by the Secretary of State.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Nestlé UK Ltd		General	Having attended the workshops with a number of key stakeholders that had not already been consulted, including the Food Standards Agency (FSA) Nestlé UK would like to know which experts were consulted in the development of this guidance. Nestlé UK believes that stakeholders should be consulted in early drafts of the guidelines, including in evidence gathering, rather than at this late stage.	Organisations are encouraged to register as stakeholders for development of guidance. Those registered for a particular topic are listed on the NICE website. Stakeholders are invited to comment on the draft scope, on the evidence gathered and on the draft guidance. In addition, all public health guidance is subject to 'fieldwork' where it is discussed with experts and practitioners in relevant areas,
Nestlé UK Ltd		General	NICE state that *"We base our decisions on evidence. The best evidence includes both published evidence and evidence based on real life experiences. Experts from top universities make sure the evidence we use is good quality and relevant. Specialists in the health topic also share their experience with us and help us see how our guidance might be put into practice. And patients and carers tell us about their experiences and help us understand what matters most to them and their families".* Nestlé UK would like to see the evidence base behind the Guidance as we believe that a number of the recommendations lack sufficient evidence to be made as stated. We have detailed some of the guidelines below and given specific information where we believe that the guidelines go against, or do not have, sufficient evidence available.	The evidence used to develop this guidance is indicated in appendix C. The reviews and expert papers are available from the NICE website.

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Nestlé UK Ltd		General	Nestlé UK would like to see an impact assessment developed for these guidelines so that cost implications can be understood by all stakeholders against the perceived benefits.	The development of the guidance includes economic modelling which has been the subject of consultation and is available on the NICE website. In addition, the final guidance will be accompanied by a costings tool which will enable local organisations to examine the costs and benefits of implementing recommendations in their area.
Nestlé UK Ltd		General	Nestlé UK would like to ask how evaluation is going to take place to determine progress made through any implementation of the guidance.	The final guidance includes a recommendation (number 12) on monitoring.
Nestlé UK Ltd		General	Nestlé UK believe that the recommendations are not sufficiently detailed to enable them to be understood and implemented by those it specifies action for. Background rationale would assist professionals to understand where the recommendations had originated from and what the intended objective of each recommendation is. The production of a preliminary document prior to the release of the recommendations would be useful to ascertain the evidence base. This could also explain why the recommendations are being introduced, what the benefits would be as a result of their implementation and the ways in which the recommendations are different to existing interventions.	Thank you. The final recommendations include an introduction and a 'policy goal' for each recommendation.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Nestlé UK Ltd		Rec 2**:** product labelling and marketing	We believe that both FoP and back of pack (BoP) nutrition labels are useful tools to improve consumer food literacy and enable them to make healthier and better informed choices for them and their families. From a UK perspective, Nestlé UK was one of the first food manufacturers to use Guideline Daily Amounts (GDA) labelling (from 2006) which is consistent with that of the majority of companies in the UK. In May 2009, there were 84 adopters of the scheme, using easily recognisable GDA icon labels, which are estimated to appear on at least 20,000 UK product lines. From a European perspective, the proposed European Union (EU) Food Information Regulation (FIR) contains provisions mostly in line with GDA labelling already used in the UK and other European countries. This is due to be adopted in the next 12-18 months. The implementation of a UK labelling scheme in advance of the adoption of FIR would result in enormous costs associated with managing two packaging changes in a very short time. It may also be the case that some of the changes suggested in this consultation may not be compatible with future EU regulations. It is also important to consider the impact on inconsistent messaging in this short time frame. Cont…	Thank you.

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Nestlé UK Ltd		Rec 2: product labelling and marketing	Many Nestlé products are manufactured across Europe and are sold as multilingual packs making the use of different national schemes difficult to manage on these packs. In particular a national scheme in the UK would affect the large majority of Nestlé products in Ireland that use joint UK/Irish packaging. We welcome the level playing field the FIR aims to create and would argue the national schemes could potentially undermine this vision. Regarding the FSA proposal of an "integrated FOP label, Nestlé supports the Food and Drink Federation (FDF) view and independent peer review, carried out by Professor Klaus Grunert of Aarhus University, in that while the PMP evidence is robust, it does not however, support the conclusions drawn by the FSA. There is a large body of evidence across Europe in support of Guideline Daily Amount (GDA) labelling FoP including the EUFIC and FLABEL research projects.	The final guidance recommends (recommendation 6) that the FSA single, integrated front of pack traffic light colour-coded systed by established as the national standard for food and drink products sold in England. It also recommends that 'the UK continues to set the standard of best practice by pursuing exemption from potentially less effective EU food labelling regulations when appropriate'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Nestlé UK Ltd		Rec 3	Nestlé is unhappy with the recommendation that states *"to persuade manufacturers to progressively change their recipes and production methods".* Nestlé has been undertaking reductions in sodium for some time and do not need to be persuaded. Significant salt reductions have and are being achieved via industry action (e.g. Nestlé have global nutrition policies in place since 1994 that require reductions in public health sensitive nutrients) as well as through voluntary partnerships with industry and the FSA via the salt reduction programme and FSA 2012 salt reduction targets. Nestlé has discussed the consumer perception, technical and safety barriers that exist with regards to further reductions in sodium in foods. Nestlé does not believe that a legislative approach is possible bearing in mind the diversity of products that exist on the market. There are clear, nationally and European wide, agreed, salt reduction targets in the form of the FSA 2012 salt reduction targets and European work being carried out. Cont…	This recommendation (now number 1) acknowledges the progress made by the food industry, working with the FSA. The PDG believe that progress towards a low-salt diet needs to eb accelerated as a matter of urgency to achieve significant reductions in premature mortality.

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Nestlé UK Ltd		Rec 3	Since 2003, the FSA has had a programme of work in place to help UK consumers reduce their salt intake. In addition, there exists a European Union High Level Group that has set up an initiative that will work towards a reduction in salt of 16% over 4 years (4% per year) against the 2008 levels. In a first stage, activities would be concentrated on 12 food categories, of which Member States have to choose at least 5 for their national plans.	See response above
Nestlé UK Ltd		Rec 4: saturated fats	Nestlé does not support the lowering of saturated fat intake from 14% of energy to 7% of energy. Nestlé would like to ask NICE to detail the evidence base on which this recommendation has been made. There is already clear national guidance in that the FSA's strategic objectives include a commitment to work with health departments/directorates and other stakeholders to reduce the average intake of saturated fat from the current level of 13.3% to below 11% of food energy by 2010 for everyone over 5 years of age, and to work with health and other departments/directorates to tackle obesity, by helping consumers achieve a balance between calorie intake and energy output. These levels of saturated fat intakes are based on COMA recommendations and supported by WHO recommendations at <10% of energy.	This recommendation (now number 2) indicates that a potentially significant number of premature deaths could be prevented by intakes of saturated fats at levels below the current recommendation. However, para 3.8 notes that the recommendations are not intended to replace existing advice to the public on diet.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Nestlé UK Ltd		Rec 5: trans fats	Nestlé would like to ask NICE to detail the evidence base on which this recommendation has been made. It is not possible to eliminate trans fats from the diet. Trans fats occur naturally in meat and dairy products from ruminant animals and are also formed in small quantities during the processing of vegetable oils. The evidence suggests that trans fats do not pose a significant health hazard in the UK. The FSA Board considered the issue in December 2007, and reviewed advice from SACN, stakeholder views, and evidence of voluntary industry action to reduce levels of artificial trans fats in food partly through the removal of hydrogenated vegetable oils. SACN advised that the available evidence supports the conclusion that trans fats have a **moderate impact** on increasing the risk of coronary heart disease, however average dietary intakes are just 1% of energy, and half SACN's recommended maximum intake. The Committee also advised that the evidence for an association between trans fats and cancer, obesity and diabetes was insufficient and contradictory. Cont…	This recommendation (now number 3) is intended to ensure that all groups in the population are protected from the harmful effects of industrially produced trans fats. The PDG is aware of the view of SACN, however felt that this recommendation was important to reduce the risk in groups in the population who may be consuming higher levels of IPTFA. The recommendation acknowledges the progress that has been made in this country and abroad, which indicate that it is possible to address this issue.

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Nestlé UK Ltd		Rec 5: trans fats	In light of this independent expert health advice, and evidence of successful voluntary initiatives by the UK food industry that have delivered consumer benefits equivalent to the most restrictive legislation, the Board recommended that mandatory restrictions are not necessary. The former Secretary of State for Health, Alan Johnson, has considered the Agency's recommendations on trans fats and agreed that the focus for action should be to reduce saturated fat in the diet through voluntary measures, while maintaining the progress already made on trans fats, as this is likely to have a significant impact on the health of the population.	See response above

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Nestlé UK Ltd		Recommendation 6: catering guidelines	There are already a number of national initiatives in place that cover catering guidelines. Nestlé believes that information should be consistent across all channels where consumers make choices regarding food and beverage purchase. FSA supports the Healthy Food Code of Good Practice efforts to improve the nutritional information available in an out of home settings by providing calories per portion data at point of purchase. This scheme differs from the integrated label approach being suggested in retail settings. Nestlé UK fully supports this scheme and has been one of the key stakeholders in the Calorie Labelling Initiative pilot undertaken over the summer of 2009; we continue to work closely with the FSA and look forward to the forthcoming consultation on the subject. Nestlé staff restaurants have carried full GDA portion information (including calories, sugars, fat, saturates and salt) for some time on sandwiches, salads, and certain menu items. Providing this information on a serving basis is fully aligned with GDA FoP labelling.	Thank you. This recommendation (now number 10) is aimed at publically funded food and drink provision.

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Nestlé UK Ltd		Recommendation 6: catering guidelines	In addition to these two schemes proposed by the FSA, the Department of Health has its draft criteria for the Healthier Food Mark to be tested in autumn 2009. The criteria suggested for the three tiered system are not consistent with the other schemes that are being suggested by the various Government Departments. This is a third scheme with additional information being displayed at the point of purchase. If consumers are to start using the information available to them to aid in decision making at the point of purchase, the information needs to be in a clear, consistent format across all channels. Nestlé UK welcomes the opportunity to work with FSA and other stakeholders to determine the best means of increasing consumer use of the nutritional information currently available for all food and drink purchases.	The PDG is aware that the Healther food mark pilot evaluation is not yet available. The recommendation (number 10) says 'assess the effectiveness of the 'Healthier food mark' pilot . If successful, develop a timetable to implement it on a permanent basis'

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Nestlé UK Ltd		Recommendation 10	Nestlé UK agrees with the statement that food and drink manufacturers have an important role to play in helping prevent CVD. Nestlé UK is disappointed that food and drink is being compared to tobacco. Consumers make the choice whether to smoke, or they don't however, have the choice whether to consume food and drink or not; these are vital for life. Nestlé UK is happy for all meetings between industry and the Government to be transparent and equally would like to see transparency with meetings between Non Government Organisations (NGOs) and the Government and Government Agencies. Nestlé UK is not happy for the content of those meetings to be made public if commercially sensitive information is being discussed. Nestlé UK would like more detail to define exactly what this proposal recommends.	Thank you. The progress made by industry and othes is acknowledged in the final guidance. The aim of this recommendation (number 5) is to ensure that dealings between the commercial sector and government are in line with best practice.
NHS Direct		General	NHS Direct welcome the guidance and make no comment on the content.	Thank you.

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NHS Sefton		Introduction, first paragraph	The CVD definition given does not include diabetes or chronic kidney disease (both of which are included in the NHS health check). There are different ways of defining CVD and since diabetes and kidney disease prevalence is increasing; would it not make sense to either include both diabetes and CKD in the definition, or give the rational as to why they have been excluded (kidney disease mentioned only once in the guidance).	This paragraph now includes a link to chronic kidney disease
NHS Sheffield		General	Supporting the recommendations that they have made regarding food and diet. NICE should be **congratulated** on their tough and firm recommendations for raising the importance of diet and food and food production and its effects on a poor diet leading to cardiovascular disease.	Thank you.
NHS Sheffield		General	UK adoption of the Mauritius example - mandatory to use polyunsaturated oils as a substitute for highly saturated cooking oils	This is referenced in para 3.27
NHS Sheffield		3.10	**Strongly agree** - Measures to encourage commercial markets to be health promoting and highly cost effective i.e improving the contents of products (re-formulation, controls on the marketing of energy dense nutrient poor high fat salt and sugar processed foods and package labelling	This is included in para 3.51
NHS Sheffield		3.11	Strongly agree - advertising promotion welcome suggestion Ofcom/Food standards agency TV advertising restrictions on foods high in salt, fat and sugar to children as an example of UK action to put these principles into practice.	This is included in 3.54-56
NHS Sheffield		3.16	local advocacy eg impact on planning applications for fast food outlets	This is now para 3.65

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NHS Sheffield		3.19	3.19 - requires a stronger emphasis on poor diet. agree with overall statement	This is now para 3.2
NHS Sheffield		3.22	3.22 strongly agree recommendations on the use of salt and saturated, unsaturated and trans fats in food	This is now para 3.9
NHS Sheffield		3.32	3.32 links to diet and to CVD is based on individual nutrients - healthy diet - balance nutrients reduction of salt and saturated fat	This is now para 3.29
NHS Sheffield		3.34	Elimination of industrial trans fatty acids - unnecessary and toxic. Recommendation that restaurant and food cooking fat manufacturer should avoid their use - strongly agree - this needs to be regulated	IPTFA (previously para 3.24) are now discussed in paras 3.44-48
NHS Sheffield		3.25	Agree concern sugar replaces fat	This is now para 3.42
NHS Sheffield		3.26	Voluntary and regulatory action - incentives for voluntary action	Para 3.37 now says 'the PDG believes the former will best be achieved by using a combination of voluntary and regulatory action'
NHS Sheffield		3.27	10% salt reduction - could be a stronger statement emphasising that this should happen - mandatory	This is now in para 3.39. It was included as an indication of the potential size of the benefit of salt reduction. Recommendation 1 suggests targets of a reduction in daily salt intake to 6g by 2015 and 3g by 2025
NHS Sheffield		3.28	Guidance focuses on salts, trans fats and saturated and poly unsaturated fats.	This is still the major focus of the final guidance

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NHS Sheffield		General	Recommendations: Strongly agree with all recommendation in particular 1. Common agricultural policy 2. Product labelling and marketing 10. Commercial interest 11. Children 14. training 15. public sector food provision	Thank you. Please note that the wording of the final recommendations has changed, as has the order of the recommendations.
Royal College of Nursing		General	We think this is a timely opportunity to promote the agenda to prevent dementia, especially in those at risk of or diagnosed with type II diabetes or CVD. Numerous papers have reviewed the incidence of dementia in those with CHD, CVD and / or diabetes and have found a link between vascular dementia and the progression of these diseases. http://www.oxfordjournals.org/our_journals/eurheartj/press_releases/dementia.pdf	Thank you for this reference. The potential impact of CVD on dementia was not included in the modelling as this took a generally conservative approach. However, this would suggest that the savings from CVD prevention could be larger than the modelling indicates
Royal College of Physicians		General	Smoking. We welcome that the draft fully accepts the recommendations of the College's report on 'Harm reduction in nicotine addiction' with regard to increasing the availability of Nicotine Replacement Therapy, in this context for people with heart disease	Thank you

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Royal College of Physicians		General	Smoking. The draft seems to have overlooked Second Hand Smoking (SHS) as a cardiovascular risk factor and also means of prevention. We believe that the list of risk factors needs to include SHA and the actions need to recommend reducing exposure to SHS.	Thank you. The PDG felt that in view of the fact that a number of NICE guidance documents have addressed tobacco use it would not be covered in the guidance. The revelant published NICE guidance documents are referenced, and the national tobacco control measures set out in 'beyond smoking kills' are endorsed (see para 3.3 and 3.4). It is likely that NICE will receive additional topics relating to tobacco. Referrals can be found on the 'public health guidance in development' page of our website (http://www.nice.org.uk/guidance/phg/indevelopment/index.jsp?d-16544-p=1).
Royal College of Physicians		General	Managing obesity in the population as a whole requires a change in attitude to exercise and to an extent this is best achieved by incorporating regular activity into the working day. Encouraging children to walk to school by limiting bus pass availability to those travelling relatively short distances to school (e.g. under a mile), restricting work place parking so people have to walk for buses and trains, encouraging development of safe pedestrian and cycle lanes and providing secure bicycle storage areas, encouraging work place based exercise (e.g. shower facilities) etc would all increase population levels of exercise and reduce obesity.	Thank you. The guidance (in addition to referencing the existing NICE guidance on promoting physical activity) includes recommendations on physical activity (see recommendations 9 and 21)

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Royal College of Physicians		General	Alcohol and its relationship to obesity, poor nutrition, child deprivation issues and its secondary role in CVD (in addition to its relationship to a wide spectrum of disease including cirrhosis and neurological impairment) is not highlighted in the current guidance. This is an important issue and need to be addressed. Much obesity and nutritional inadequacy, particularly in middle-aged and older men, is related to excessive alcohol intake. The need for targeting alcohol abuse, encourage reduction in alcohol intake, decreasing availability, avoiding the availability of cheap alcohol and taxation ass need to be considered.	The final guidance notes that it complements the guidance on alcohol misuse (due for publication in June 2010). Excess alcholol consumption is identified as a risk factor in section 2 and para 3.2.
Royal College of Physicians		General	It is very likely that people will continue to 'snack' on unhealthy foods and every effort should be made to encourage manufacturers to improve the nutritional composition of snack type foods (e.g. crisps) by reducing fat, salt and TFAs where ever possible. Ensuring vending machines contain healthy alternatives particularly at school and making these cheaper than unhealthy options is important. Likewise, reducing 'take-away' availability in the vicinity of schools would be helpful.	Thank you. Reformulation and location of 'take away' and other food retail outlets are addressed in the recommendations.

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Royal College of Physicians		General and section 3.19-21	Changing attitudes to nutrition and smoking in the school and young adult populations is likely to be the most effective way of reducing future cardiovascular disease. Nearly 80% of smokers start as teenagers and in young women the most important factors associated with smoking are weight reduction and stress relief. By addressing these underlying factors it may be possible to have greater effectiveness in encouraging young people not to start smoking. Thus advice on how to avoid weight gain and to deal with stress may help young adults avoid smoking and at the same time improve diet (i.e. a combined approach)	Thank you. The provision of advice to individuals is beyond the scope of this guidance which looks at population approaches. This approach is likely one to be used by smoking cessation services.
Royal College of Physicians		Section 3.26	We would strongly support the concept of reducing salt in processed food. If this cannot be achieved by voluntary agreement with the manufacturers we would suggest that legislation or taxation should be considered to limit salt levels in food.	Thank you. This is addressed in paras 3.37 – 40, and salt is the subject of recommendation 1.
Royal College of Physicians		Section 3.24	As for salt, reducing levels of saturated fat in processed foods and where possible replacing with polyunsaturated fats should be strongly encouraged by legislation or taxation.	This is now addressed in 3.41-43 and by recommendation 2.

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Royal College of Physicians		Section 3.28	Making sport and exercise fun. Attitudes to exercise are formed at school. Many young people are 'put-off' the concept of exercise and sport as a consequence of their school experience. The types of physical activity, culture of humiliation associated with team sports (i.e. less sporty children stigmatised) and the mandatory nature of these activities results in many children perceiving exercise as an unpleasant experience. These experiences may result in a lifelong aversion to physical activity. Physical education and sports activity needs to be carefully reviewed to encourage less 'sporty' children into forms of exercise that would better suit their needs. The aim should be to encourage life-long healthy pursuits and a healthy attitude to exercise by encouraging activities that may not always be considered by schools, like trekking, cycling, dancing or golf rather than the traditional competitive team sports. Other activities may be gender specific like aerobics. The aim should be to encourage life long physical activity in these less 'sports' orientated groups.	Thank you. This is an important issue which is addressed in NICE guidance 17 on promoting physical activity for children and young people. This guidance is referenced in para 3.50 and in recommendation 15 (regional CVD prevention programmes – programme development) and 21 (physical activity)

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Royal College of Physicians		Section 3.29	It would be worth considering extending food labelling (particularly estimates of energy and macronutrient content) to include restaurant and take-away food. As is mentioned elsewhere in the document, food eaten outside the home contributes significantly to unhealthy eating and obesity, yet these 'hidden' calories are not routinely quantified at the point of purchase. It is recognised that there will be logistic difficulties with this, but it should be possible to provide reasonable approximations for the majority of such foods.	Thank you. This is an interesting area which is part of the Healthier food mark scheme (see http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/HealthierFoodMark/Draftschemecriteria/index.htm). As noted in recommendation 10, this is currently the subject of piloting. The recommendation includes the development of a timetable to implement it on a permanent basis.
Royal College of Physicians		Sections 3.9-3.11	It will require both population and individual approaches in equal measure to address the nutritional aspects associated with cardiovascular disease. Undoubtedly reducing salt and saturated fats in manufactured food by voluntary agreement with the manufacturers (+/- taxation, tariffs etc) would be one of the most effective means of improving diet and can be shown to have a significant impact. However, education, particularly aimed at the school population, mothers and institutions and changing attitude to diet and nutrition is likely to be equally (or more) effective and if appropriately directed with the associated support (i.e. cheap fruit and healthy foods) would have the greatest impact on socially and financially deprived communities.	Both population- and individual-based approaches are important (see para 3.16). however, the subject of this guidance is population-based approaches (see also para 3.11)

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Royal College of Physicians		Section 4 recommendation 1	Whilst reform of the CAP to encourage CHD prevention is to be encouraged, it is noted that this includes production of predominantly 'low fat' dairy products. It is difficult to see how this can be achieved without a substantial reduction in overall dairy production, as in the end, everything produced will end up in the food chain within the EU, unless it is sold outside the EU, which would effectively imply exporting the problem elsewhere. It should also be acknowledged that production of 'low fat' products is often associated with increases in salt and sugar content of foods.	This recommendation (now number 6) aims to optimise the public health outcomes from CAP spending. It says 'encourage the principle that future 'pillar two' funds should reward or encourage the production of highly nutritious foods such as fruit, vegetables, whole grains and leaner meats' Para 3.42 notes that there is a risk of fat content being replaced with high levels of sugar
Royal College of Physicians		Section 4 recommendation 2	See comment above with respect to expanding labelling regulations to include take-away and restaurant food.	This is an interesting area which is part of the Healthier food mark scheme (see http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/HealthierFoodMark/Draftschemecriteria/index.htm). As noted in recommendation 10, this is currently the subject of piloting. The recommendation includes the development of a timetable to implement it on a permanent basis.
Royal College of Physicians		Section 4 recommendation 3	The recommendations on salt are to be commended, but the development of fiscal incentives to reduce salt content of cheaper foods is likely to be challenging, as high salt content is often used to disguise inferior ingredients.	This recommendation is now number 1. The PDG feel that there is still room for significant reductions in salt content of several food categories (bread, meat, cheese, snacks, cereals, soups, ready-meals) before invoking costly replacers

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Royal College of Physicians		Section 4 recommendation 12	Labelling should be more detailed and include energy content for take away and restaurant food	Food provided by the public sector, where more control can be exerted, account for a third of the meals eaten outside the home. This is addressed in recommendation 10, which as indicated above includes the development of a timetable for implementation of the Healthier food mark scheme if the pilot is found to be successful
Royal College of Psychiatrists		General	Although it lists 'psychosocial stress' as one of the risk factors for CVD, the guidance would be enhanced by a clear statement about the factors which comprise this concept (such as 'mental health', 'depression' and 'anxiety'). Anxiety is associated with X6 risk of dying of coronary heart disease,[ii] while 'there is strong evidence that depression is associated with an increased risk of cardiovascular disease and cardiac death'[iii]; furthermore 'once an individual develops depression, especially if it is recurrent, that illness brings with it a number of health behaviours that will unquestionably increase the risk for vascular disease. It has repeatedly been shown that depressed individuals are less likely to take care of their health, they are less likely to exercise, and are more likely to be obese and find it difficult to stop smoking'.[iv] There is no reference to heightened cardiovascular pathology in those suffering with mental health problems or taking psychotropic medication in the evidence section of the consultation and that is a significant omission.	Thank you. The PDG agree that these are important issues, however the focus of the guidance is the development of recommendations for population level prevention of CVD. Development of recommendations for people with specific clinical conditions or or medication in not within the remit of this guidance.

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Royal College of Psychiatrists		General	The College would therefore like to see the guidance make reference to *mental health* as a target area, and either include guidance on better prevention, detection and treatment of mental illness, or make direct links between its recommendations and those of other relevant NICE guidelines (such as *Antenatal and postnatal mental health*; *Anxiety; Depression in adults; Depression in children and young people; Depression with a chronic physical health problem).*	Thank you. This is outside the remit of the guidance.
Royal College of Psychiatrists		2	In relation to 'Upstream effects' there are medication effects on weight and endocrine function (e.g. diabetes) in which manufacturers have responsibility for iatrogenic effects on cardiovascular risk.	Although this is important for those on specific medication it is outside the remit of this guidance. It would be relevant to guidance produced to address the underlying condition.
Royal College of Psychiatrists		3.2	The section on health promotion could and should reference care and attention to the reduction of CV risk in patients of mental health services. There should also be cross-reference to the acute care of mental health patients and the acute services provision to patients with mental health or learning disability problems passing through the acute sector.	This paragraph is now addressed in 3.11 to 3.16. This looks at different approaches (individual- and population-based) to addressing CVD. Recommendation 14 says 'identify groups of the population who are disproportionately affected by CVD and develop strategies with them to address their needs'. Recommendation 15 notes the importance of links with screening (including the NHS Health checks programme). These should assess CVD risk in individuals whatever co-morbidities they may have.

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Royal College of Psychiatrists		General	There should be mention of commissioner responsibility to purchase holistic packages of mental health care which address CV risk and physical health promotion.	As indicated above, recommendation 14 says 'identify groups of the population who are disproportionately affected by CVD and develop strategies with them to address their needs'. Commissioning of packages of mental health care is outside the remit of this guidance.
Royal College of Psychiatrists			References: i. Feast, S. *Wellbeing in mental health.* Birmingham October 2009 Senior Advisor Health and Wellbeing, Department of Health ii. Glassman, A. H. Depression and cardiovascular comorbidity. Dialogues in Clinical Neuroscience Vol 9 **.** No. 1 **.** 2007 iii. Glassman, A. H. Depression and cardiovascular comorbidity. Dialogues in Clinical Neuroscience Vol 9 **.** No. 1 **.** 2007 iv. Glassman, A. H. Depression and cardiovascular comorbidity. Dialogues in Clinical Neuroscience Vol 9 **.** No. 1 **.** 2007	

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Royal College of Psychiatrists		3.19 and General	Although alcohol is mentioned as a risk factor, there is really no detailed discussion of its role or the effect of reducing alcohol consumption in mid to late life; the guidance therefore misses an opportunity to make an important educational point about the relative impact of alcohol excess on the genesis of cardiovascular disease. Given the rising levels of alcohol consumption over the age of 50, as well as in younger people, a section on the contribution of alcohol would enhance the guidance in its present form.	The final guidance notes that it complements the guidance on alcohol misuse (due for publication in June 2010). Excess alcholol consumption is identified as a risk factor in section 2 and para 3.2.
Royal College of Psychiatrists		4	The document also should refer to the link between childhood adversity and cardiovascular disease. Research shows that 'there is a strong association between early abuse and neglect and subsequent depression, drug abuse, and ischemic heart disease. There is some evidence to suggest that childhood maltreatment, including both abuse and neglect, influences depression and heart disease in ways that are gender-dependent'.[v]	Thank you. Referral to this link has been added to the considerations section (see 3.29)

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Self Employed Nutritionists Support & Enlightenment (SENSE)		3.24	I agree that food service, restaurants and food and cooking fat manufacturers should avoid trans fats as has been successfully achieved in Denmark and New York. Evidence indicates that the UK population has been eating out more over recent years and that during the recession "fast food" takeaways are increasingly consumed because of price. It is therefore important to avoid the use of trans fats in these establishments, and indeed all others of whatever type. However, care should be taken on replacement fats – eg, there should be no increase in saturated fats and no increase in unsustainable fats such as palm oil sourced from unsustainable sources.	Thank you. International examples are highlighted in para 3.44 and recommendation 3. Recommendation 3 also addresses the use of replacement fats and says 'encourage the use of vegetable oils high in polyunsaturated and monounsaturated fatty acids to replace oils containing IPTFAs. Saturated fats should not be used as an IPTFA substitute'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Servier Laboratories Ltd		General	The 4th ESC Guidelines on cardiovascular disease prevention in clinical practice make reference to heart rate and prognosis and makes recommendations for lifestyle changes to reduce resting heart rate. However, no mention is made in this guidance on the importance of heart rate as an important factor in monitoring CVD. The ESC Guidelines state the following: Elevated heart rate has been shown to be associated with increased risk of all-cause mortality, CVD mortality, and development of CVD in the general population, hypertensives, diabetics, and those with pre-existing coronary artery disease.82,83 The relationship is also seen in animal models. Levine demonstrated the semi-logarithmic inverse relationship between heart rate and life expectancy in mammalian species.84 A reduction in the development of atherosclerosis has been demonstrated in cholesterol-fed monkeys after pharmacological or surgical reduction of heart rate.85	Thank you. The guidance addresses physical activity, which promotes physical fitness. As noted below, heart rate is a surrogate marker of physical fitness. The guidance presents population level recommendations for the prevention of CVD. The potential use of heart rate as a marker of fitness in screening or as a diagnostic test is outside the remit of this guidance.

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Servier Laboratories Ltd		General	Most epidemiological studies have shown the relationship to be strong, graded, and independent of other factors including BP and physical activity. While virtually all of the studies demonstrated a significant effect in men, the relationship between CVD mortality and elevated heart rate in women and the elderly was non-significant after multivariate adjustment in some of the studies. Risk of sudden death in men is particularly associated with elevated resting heart rate.86. In the light of the ESC Guidelines attention to heart rate as a risk factor, it would seem advisable to cover this in the current guidance.	Thank you.
Servier Laboratories Ltd		Page 5 Paragraph 5 *Risk Factors*	The guidance quotes Yusuf (2004) as a source for defining Risk Factors. We would like to draw your attention to Borer JS, EHJ Supplements (2008) 10 (Supplement F), F2-F6. This paper is a more up-to-date publication on the assessment of risk factors. Borer (2008) highlights the growing acceptance of heart rate as a risk factor.	Thank you. The PDG feel that Yusuf is a suitable source for defining risk factors.
Servier Laboratories Ltd		General	The guidance mentions physical activity extensively as a risk factor for CVD. Heart rate is a surrogate marker of physical fitness and thus should be included in the guidance.	Thank you. As noted above, the potential use of heart rate as a marker of fitness in screening or as a diagnostic test is outside the remit of this guidance. Recommendations on physical activity that have an impact on physical fitness will be likely to impact on heart rate.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Servier Laboratories Ltd		General	Resting heart rate is an important cardiovascular parameter that can be simply and inexpensively measured and recorded. The relationship between elevated resting heart rate and increased risk of cardiovascular morbidity and mortality in the general population has been extensively reported[vi,vii,viii,ix]. A study published by Dyer *et al.* demonstrated a positive association between resting heart rate and all-cause mortality in men[iv]. Furthermore, the Framingham Heart Study, one of the largest studies to date, followed a cohort of 5209 men and women aged over 35 years for 30 years. Results indicated that all-cause mortality and cardiovascular mortality rates increased progressively in association with resting heart rate in both men and women, although the risk was significantly higher in males[x]. A recent study including over 5000 men aged 42–53 years found that subjects with a resting heart rate over 75 bpm had an increased risk of sudden death by myocardial infarction during a 23-year follow-up period (relative risk 3.92 vs 1.00 heart rate < 60 bpm)[xi].	Thank you

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Servier Laboratories Ltd		General	Resting heart rate has been shown to cluster with several cardiovascular risk factors have, including physical fitness, obesity, diabetes, hypertension and dyslipidaemia[vii,viii] and HR correlates with the number of cardiovascular risk factors present in an individual[ix]. However, it is important to note that heart rate remains a strong independent predictor of risk after adjustment for accepted risk factors in the recent epidemiological studies [iv,x,xi] Although a number of studies confirm the association between resting heart rate and cardiovascular mortality in men, not all studies have confirmed a similar association in women[iii,iv,xii,xiii]. Such findings may be attributable to the smaller population size and also the lower death rates in women – that will have reduced statistical power.	Thank you

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Servier Laboratories Ltd		General	Data from a study by Benetos *et al*, who examined the association between heart rate and cardiovascular mortality in approximately 20,000 healthy subjects in France (aged 40–69 years), demonstrate a stronger association between heart rate and cardiovascular mortality in men than women[iv]. It is worth noting that the association between resting heart rate and outcome in men in this study remained evident after adjustment for systolic and diastolic BP, BMI, history of MI, hypertensive treatment, total cholesterol level, physical activity, and tobacco consumption) suggesting and independent predictive role of heart rate. The large size of the population in this study does provide data to support the gender differences in cardiovascular risk. A more recent study showed that in disabled older women without heart disease, the association of elevated heart rate with increased mortality remained[xiii]. There are several pathophysiological hypotheses that could explain the epidemiological association between resting heart rate and outcome, which are discussed below. These give some indication as to how an elevated heart rate could lead to the development of acute and chronic cardiovascular diseases.	Thank you

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Servier Laboratories Ltd		General	Increased heart rate favours the occurrence of injury to the arterial wall[xiv]. The haemodynamic wall stress may perturb intracellular junctions, increase permeability of the endothelial cells, and favour atherogenesis. Experimental studies in cyanomologus monkeys strongly suggest that increased heart rate has a direct action in promoting the development of atherosclerotic plaques[xv]. In animals with higher heart rates the number and severity of coronary artery lesions were more than twice that of control animals. In a study of 116 survivors of myocardial infarction it was found that the development of atherosclerosis was higher in subjects with a high heart rate and that the coronary stenosis score doubled in this group[xvi]. The excessive mechanical stress that elevated heart rate places on cardiovascular arteries is also likely to increase the probability of atherosclerotic plaques rupturing. Indeed, a heart rate greater than 80 bpm has been shown to be associated with increased frequency of plaque disruption[xvii].	Thank you

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Servier Laboratories Ltd		General	Acute cardiovascular events such as unstable angina, myocardial infarction or sudden cardiac death are usually triggered by the development of plaque disruption and thrombus formation. Haemodynamic forces and high heart rate may play a particularly important role in the pathogenesis of plaque disruption. Indeed, a study recently observed a positive and independent relationship between future development of plaque rupture and mean baseline heart rate greater than 80 bpm in patients who underwent coronary angiography procedures[xviii]. Whilst the effects of pharmacologically lowering resting heart rate in the general population is unknown, lifestyle adaptations that are associated with a reduction in resting heart rate are generally felt to be beneficial (e.g. exercise, smoking cessation, weight loss). In addition, there is robust clinical evidence showing a significant benefit of heart rate reduction associated with beta-blocker use in patients who have experienced a myocardial infarction or who have left ventricular dysfunction / heart failure[xix].	Thank you. The guidance presents population level recommendations to address CVD. These will address (among other things) the lifestyle adaptations you indicate to be beneficial. Clinical interventions (such as the use of beta-blockers to reduce heart rate) are outside the scope of this guidance.
Servier Laboratories Ltd		General	In summary, resting heart rate independently and robustly predicts all-cause and cardiovascular mortality in the general population. Heart rate can be easily measured and recorded, and provides clinicians with important information when evaluating patients.	Thank you. This information would potentially be of significance to clinicians when assessing patients. Unfortunately this is outside the remit of this guidance.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Servier Laboratories Ltd		General	For references see Appendix 2 at end of document.	Thank you.
South Asian Health Foundation		General	We are very much in favour of this guidance, especially as a means for government to pressure industry to change.	Thank you
South Asian Health Foundation		Page 29	Recommendation 8. We should continue to encourage cycling, and any move towards making it more difficult to do such as registration schemes for bicycles and other such ideas must be discouraged.	Thank you. Active travel and physical activity are addressed in recommendations 9 and 21.
South Asian Health Foundation		Page 25	A even lower target for salt intake is not worth pursuing	Recommendation 1 presents a target of a daily intake of 6g by 2015 and 3g by 2025 based on the substantial savings in premature mortality.
South Asian Health Foundation		Page 27	The potential impact of a ban on industrial trans fats on cardiovascular disease would be significant, and also be an advert for public health prevention to try and encourage more natural and healthy ways of food production. Unlike other dietary fats, trans fats are not essential. The potential effects on existing inequalities in health may will be positive, as these partially hydrogenated fats have displaced natural solid fats and liquid oils in many areas, notably in the fast food, snack food and fried food industries.	Thank you. This is now recommendation 3

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Sustrans	'Take action on active travel', Sustrans 2009	General	We very much welcome this guidance. We welcome its acknowledgement of the importance of active travel – regular walking and cycling – as forms of physical activity easily incorporated into the daily lives of individuals who are currently insufficiently active. And we particularly welcome your clear recognition of the importance of the environment in determining the lifestyle choices of individuals – in choosing active travel and in other areas of CVD prevention.	Thank you.
Sustrans		Recommendation 8	We wish particularly to support the recommendation to "place direct taxes on the provision of car parking used as a benefit." At a time when certain lobbies, including some within the health sector, are successfully demanding free workplace parking – which is no more nor less than a subsidy to sedentary and polluting forms of transport – this recommendation is most valuable.	Recommendation 9 now says 'consider and address factors which discourage physical activity, including physically active travel to (and at) work. An example of the latter is subsidised parking'
Sustrans		Recommendation 9 / recommendation 13	We strongly support these two recommendations. Effective health impact assessment of transport and planning policies, at all levels, would go a long way to shifting planning and implementation in the built environment, away from domination by private motorised transport and towards active-travel-friendly environments.	These issues are now addressed in recommendations 7 and 22. The recommendations also refer to NICE guidance 8 on physical activity and the environment (see for instance recommendations 15 and 21)

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Sustrans		Recommendation 17	In recent years "planning gain" resources have occasionally been directed towards measures promoting active travel, both environmental – infrastructure improvements – and motivational – eg TravelSmart individualised travel marketing. This recommendation recognises best practice, in our view.	Thank you. This is now included in recommendation 21
Sustrans		Recommendation 18	The first bullet ("Ensure cycle tracks are part of the definitive map…..") is rather detailed and should be relocated further down the list. The second ("Prioritise the needs of pedestrians and cyclists over motorists when developing or redeveloping streets") is of greater strategic importance and should be ranked higher.	The first bullet point of this recommendation (now 21) emphasises the importance of ensuring the physical environment promotes activity (referenced to NICE guidance 8). This includes prioritising the needs of cyclists and pedestrians. The point about cycle tracks is now in bullet point 6

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Sustrans		Recommendation 18	The final recommendation ("Allocate part of the budget for road building to promote walking, cycling and other forms of travel that involves physical activity") is vague. Local highway authorities could argue that they do already "allocate part" – the problem of course is that the "part" is too small. We suspect also that evidence may be lacking for the "other forms of physical activity". We ask you therefore to consider wording along the lines of "Allocate a larger proportion of transport investment to measures and schemes which promote walking and cycling, in line with ambitious targets for growth in these modes". This wording would fall in line with the demands in the policy call "Take action on active travel", signed by well over 100 public health and other bodies (attached). This recommendation is also of great strategic importance and as such should be ranked higher – first or second.	Thank you. This has been added to recommendation 21

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Sustrans		Recommendations 19 - 24	Is it possible at some point within this group of recommendations to encourage PCTs to engage strategically with their local authority partners, encouraging the authorities in their turn to implement the parts of this and other NICE guidance which relate to them? We know from field tests of the PH008 guidance that local authorities are slow to act on guidance from NICE; it may be that the guidance can have more impact on local authority decision making if it is mediated through and supported by the local NHS.	These recommendations (now 13 – 18) refer to related NICE guidance, including on physical activity and the environment. Recommendation 13 refers to 'good practice principles', incluiding ensuring programmes take account of issues identified in recommendations 1-12 (which include active travel). Recommendation 14 includes consideration of how existing policies (including those developed by the local authority) impact on the prevalence of CVD locally.
Syner-Med (PP) Ltd		General	Anaemia is a very common co-morbidity in the general population and is increasingly being associated with cardiovascular events. The most common cause of anaemia is iron deficiency. Correction of IDA is simple and very inexpensive and can have significant positive impact on patient's quality of lives and their general and cardiovascular health.	Thank you. The identification and treatment of anaemia is outside the scope of this guidance which considers population level recommendations on the prevention of CVD. The quidance endorses the 'eatwell' plate which sets out a balanced diet suitable for the general population. Addressing anaemia would potentially be relevant as part of a clinical screening programme of people for CVD. This is referenced in recommendation 15, and the identification of groups in the population who are disproportionately affected by CVD and the development of strategies to address their needs is addressed in recommendation 14.

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Syner-Med (PP) Ltd		General	Anaemia has been identified as an important, frequently occurring co-morbidity in patients with HF as well as many other manifestations of cardiac disease. In patients with HF, anaemia has been linked to impaired exercise tolerance, worse New York Heart Association (NYHA) functional class, and worse renal function. More importantly, anaemia has been described as a powerful independent predictor of death and hospitalization in patients with systolic and diastolic dysfunction as well as in patients with new-onset and severe HF and in those undergoing per-cutaneous coronary intervention (PCI). A study by Horwich et al, for example, showed that survival rates of patients with advanced HF steadily decreased with decreasing hematocrit. Several studies have now shown that renal insufficiency and anaemia are independent risk factors for death and hospitalization in these patients, and that mortality is especially high when both conditions are present .	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Syner-Med (PP) Ltd			Coronary artery disease is the number 1 cause of HF. The prevalence of anaemia and its impact on clinical outcomes in patients with ischemic heart disease is currently being investigated. In a study of women undergoing evaluation for suspected ischemic heart disease, 21% had anaemia (haemoglobin _12.0 g/dL), and women with anaemia had a significantly higher risk of all-cause death than women without anaemia (10.3% vs 5.4%, p _ 0.02). In patients undergoing PCI, anaemia occurs frequently (10%–30% of these patients have anaemia) and is associated with adverse clinical outcomes. As reported in several studies, patients with anaemia showed significantly higher in hospital mortality rates and a higher number of major cardiovascular events, and they were significantly more likely to die from all-cause or all-cause and cardiac-specific cause during follow-up than patients without anemia.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Syner-Med (PP) Ltd			Information, although limited, is also available on the impact of anemia in patients with myocardial infarction (MI). Specifically, in patients hospitalized with acute MI, anaemia has been associated with significantly higher 1-year and 30-day mortality rates as well as more frequent in hospital events of shock, HF, and death. In patients undergoing coronary artery bypass surgery, Zindrou et al showed that a low preoperative hemoglobin concentration (<10.0 g/dL) was associated with a significantly higher postoperative mortality rate compared with patients who had a hemoglobin value >10.0 g/dL. **Am J Cardiol 2007;99[suppl]:15D–20D Mitchell**	Thank you.
Syner-Med (PP) Ltd		General (Particularly relevant to patients who are at high risk of CKD, Diabetics, Elderly and patients with CVD)	Anemia is a common feature of CKD, particularly in end-stage renal disease. Anaemia is also independently associated with poorer outcomes in a wide variety of CVD states, including congestive heart failure and coronary artery disease. Anaemia appears to act as an independent mortality multiplier when haemoglobin levels drop below 12 g/dL. Rev Cardiovasc Med 2005 (6) Suppl	Thank you.

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Syner-Med (PP) Ltd		General (Particularly relevant to patients who are at high risk of CKD, Diabetics, Elderly and patients with CVD)	Anemia is a potential non-traditional risk factor for cardiovascular disease (CVD). Authors found that anemia is a risk factor for adverse CVD and all-cause mortality outcomes primarily in participants who also have CKD. The combination of anemia and CKD confers a particularly high-risk group for adverse outcomes. McColough 2005 (6) Suppl3 S4-12. 'Piecing together the evidence on anemia and the link between CKD and CVD'.	Thank you.

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Syner-Med (PP) Ltd		General (Elderly patients)	Estimates of anemia prevalence reported in the articles reviewed here range from 2.9% to 61% in elderly men and from 3.3% to 41% in women. Whereas anemia is associated with symptoms ranging from weakness and fatigue to increased falls and depression, and in severe cases can lead to congestive heart failure, few studies have systematically examined functional, clinical, and economic outcomes or patient satisfaction in the elderly with anemia. Prevalence and Outcomes of Anemia in Geriatrics: A Systematic Review of the Literature Am J Med. 2004;116(7A):3S–10S. A Symposium: Anemia in Geriatrics: A Systematic Review of the Literature/Beghe´ et al.	Thank you.

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Syner-Med (PP) Ltd			Data from a total of 7,536 elderly with blood tests were available to estimate mortality; full health information available to evaluate health related outcomes was available for 4,501 of these elderly subjects. Mild grade anemia was defined as a hemoglobin concentration between 10.0 and 11.9 g/dL in women and between 10.0 and 12.9 g/dL in men. After controlling for many potential confounders, mild grade anemia was found to be prospectively associated with clinically relevant outcomes such as increased risk of hospitalization and all-cause mortality. Whether raising hemoglobin concentrations can reduce the risks associated with mild anemia should be tested in controlled clinical trials. Association of mild anemia with hospitalization and mortality in the elderly: the Health and Anemia population-based study. Riva E, Haematologica | 2009; 94(1)	Thank you.

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Syner-Med (PP) Ltd		General	In this present review we examine the physiologic response to chronic anemia and describe potential adverse effects of anemia on myocardial and large arterial remodeling. We present observational data demonstrating that anemia is a risk factor for cardiovascular disease (CVD) outcomes in patients with chronic kidney disease and patients with heart failure. We also present data that have evaluated the relationship of level of hematocrit to CVD outcomes in patients with ischemic heart disease and in patients in the general population. The results from the latter studies have been inconclusive and have been limited by lack of knowledge of the cause of anemia. This is potentially important because iron deficiency anemia may, in fact, improve endothelial function. Kidney International Suppl 2003 Nov (87) S32-9. Anemia as a risk factor for CVD. Pereira AA, Sarnak MJ	Thank you

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Syner-Med (PP) Ltd		General (Elderly)	Anemia in older individuals is associated with a very wide range of complications, including increased risk for mortality, cardiovascular disease, cognitive dysfunction, longer hospitalization for elective procedures and comorbid conditions, reduced bone density, and falls and fractures. Not surprisingly, anemia also has a significant effect on quality of life (QOL) in the elderly. Most anemia in older individuals results from iron deficiency, chronic inflammation, or chronic kidney disease, or it may be unexplained. Anemia in the elderly: Current understanding and emerging concepts Richard Eisenstaedt Blood Reviews (2006) 20, 213–226	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Syner-Med (PP) Ltd		General (Elderly)	Although anemia is common in older adults, its prognostic significance is uncertain. A total of 17 030 community dwelling subjects 66 years and older were identified between July 1 and December 31, 2001, and followed until December 31, 2004. Cox proportional hazards analyses were performed to determine the associations between anemia (defined as haemoglobin < 110 g/L) and hemoglobin and all-cause mortality, all-cause hospitalization, and cardiovascular-specific hospitalization. Overall, there were 1983 deaths and 7278 first hospitalizations. In patients with normal kidney function, adjusting for age, sex, diabetes mellitus, and comorbidity, anemia was associated with an increased risk for death (hazard ratio [HR], 4.29; 95% confidence interval [CI], 3.55-5.12), first all-cause hospitalization (HR, 2.16; 95% CI, 1.88-2.48), and first cardiovascular-specific hospitalization (HR, 2.49; 95% CI, 1.99-3.12). An inverse J-shaped relationship between haemoglobin and all-cause mortality was observed; the lowest risk for mortality occurred at haemoglobin values between 130 to 150 g/L for women and 140 to 170 g/L for men.	Thank you.

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Syner-Med (PP) Ltd		General (Elderly)	Anemia is associated with an increased risk for hospitalization and death in community- dwelling older adults. Consideration should be given to redefine “normal” hemoglobin values in the elderly. Clinical trials are also necessary to determine whether anemia correction improves quality or quantity of life in this population. BLOOD, 15 MAY 2006 _ VOLUME 107, NUMBER 10 Impact of anemia on hospitalization and mortality in older adults Bruce Culleton Because anemia may increase fall risk, adequate assessment of the cause(s) of anemia and conservative recommendations to correct it may decrease fall risk. Medication interventions for fall prevention in the older adult James W. Cooper *J Am Pharm Assoc.* 2009;49:e70–e84.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Syner-Med (PP) Ltd		General (Elderly)	In reference to our hypotheses, the literature suggests that low haemoglobin or anaemia increases the risk of incident dementia or cognitive decline, although the available studies are few. BMC Geriatrics 2008, 8:18 Peters R, Haemoglobin, anaemia, dementia and cognitive decline in the elderly, a systematic review	Thank you.
Syner-Med (PP) Ltd		General	We investigated whether the presence of anemia is a risk factor for cardiovascular disease (CVD) outcomes in the general population. The Atherosclerosis Risk in Communities (ARIC) study was used to evaluate the relationship of anemia, defined by hemoglobin <13 g/dl in men and <12 g/dl in women, to CVD. A total of 14,410 subjects (6,267 men and 8,143 women) without CVD at baseline had hemoglobin levels measured. Anemia is an independent risk factor for CVD outcomes in the ARIC cohort, a community cohort of subjects between the ages of 45 and 64 years. **Anemia as a risk factor for cardiovascular disease in The Atherosclerosis Risk in Communities (ARIC) study.** 2002 Jul 3;40(1):27-33. Sarnak MJ.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The Advertising Association		General	The Advertising Association represents all sides of the advertising industry, including advertisers, advertising agencies, and the media. The recommendations on marketing go well beyond, and should fall outside, the scope of NICE's public health guidance, which has been requested by DH to develop practical prevention and early identification measures. The recommendations ignore the fact that advertising falls within the remit of the DCMS and related regulatory and self-regulatory agencies – Ofcom, the OFT and the Advertising Standards Authority (ASA), and not within NICE's remit. We find it surprising that NICE has made far-reaching proposals for new advertising and marketing restrictions without consulting either the Advertising Standards Authority or the advertising industry, through the Advertising Association. Such an approach ignores Best Practice Better Regulation Principles, which require bodies to consult the industries concerned, evaluate the impact on the industry of the proposals, and be clear about the outcomes.	Thank you. NICE's Statutory Instrument was amended in 2005 when it took on the production of public health guidance. This allows NICE to address a wide range of audiences beyond the NHS. The referral for this guidance was to produce guidance on the prevention of cardiovascular disease at population level. 'Population' and 'individual' approaches are discussed in section 3.11 – 21. As well as consulting stakeholders on the scope and evidence, NICE public health guidance is put out in draft form for comment, and the draft guidance is taken though a process of 'fieldwork' where it is discussed with relevant professionals and groups. In this case this was done on NICE's behalf by Greenstreet Berman. The Advertising Standards Authority were contacted to take part in this process.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The Advertising Association		Recommendation 2: Product labelling and marketing (p.25)	**Action:** Develop legislation to implement the Food Standards Agency's Integrated Label for products sold in England. This includes traffic light colour-coding, text to indicate high, medium or low content of particular ingredients and the percentage guideline daily amount (GDA). Implement the system in advance of legislation. The Food and Drink Federation (FDF) should be consulted on this point. Restrict advertising for products that fall into the amber and red categories of the Food Standards Agency's food labelling system. There are already rules in place, introduced by Ofcom in 2007, to restrict the advertising to children of products high in fat, salt and sugar (HFSS) in broadcast media. The classification of products into the HFSS category is made on the basis of the Nutrient Profiling System that was devised by the Food Standards Agency specifically for this purpose. Advertising is therefore covered and does not require any more rules or regulations. Suggesting that yet another system is used for the classification of products would only create confusion.	The bullet point referring to restriction of advertising for products that fall into the amber and red categories has been deleted.

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The Advertising Association		Recommendation 2: Product labelling and marketing (p.25)	Moreover, NICE has not made an impact assessment or assessed the outcome of such a recommendation which would ban from advertising products such as salmon or seeds and nuts for falling into the red category as they have a very high fat content. Clearly label products requiring a high salt content (such as some cheeses and meat products) to indicate that they are high in salt and should only be considered for occasional consumption. The Food and Drink Federation (FDF) should be consulted on this point.	See comment above. This has been amended (now in recommendation 1) to clarify that this labelling should use the Food Standards Agency traffic light system.
The Advertising Association		Recommendation 10: Commercial Interest (p.30)	**Action:** Introduce a similar framework for food and drink production to that adopted by the World Health Organization for tobacco control (that is, Framework convention on tobacco control [2003]). The Food and Drink Federation (FDF) should be consulted on this point. Ensure all meetings, including lobbying, between the food and drink industry and government and government agencies are conducted in a transparent way. Except for those cases when meetings may involve releasing commercially-sensitive information or covering areas that might breach Competition Law.	This bullet point has been deleted. This recommendation (now number 5) now says 'encourage best practice for all meetings, including lobbying, between the food and drink industry and government (and government agencies). This includes full disclosure of interests by all parties. It also involves a requirement that information provided by the food and drink, catering and agriculture industries is available for the general public and is auditable.'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The Advertising Association		Recommendation 11: Children (p.30-1)	**Action:** Developing an agreed framework of principles for food marketing aimed at children. This could be similar to the "Sydney principles". The framework should be comprehensive and should be based on children's rights to a healthy diet. There are already extensive rules in place in the UK to restrict the advertising of food and drink products to children, whilst at European level, food advertisers have pledged at the EU Platform on Diet, Physical Activity and Health voluntarily to change the products they advertise to children under 12. The WFA (World Federation of Advertisers) has recently published some independent monitoring results (9.9.09) demonstrating significant declines in HFSS food advertising to children. Children will inevitably be exposed to some food and drink advertising but it is important that it is not directly targeted at them and that when it is targeted at children, it is covered by the existing rules. The rules are comprehensive and binding on all parties. They afford substantial protection to children, apply to all media and are independently evaluated, monitored and enforced.	Thank you. The PDG are aware of the restrictions on advertising of food and drink products to children and feel that further restriction of the scheduling of advertising is warrented. This recommendation (now number 4) has been amended and now recommends restricting advertising of HFSS food up to the 9pm watershed to provide protection for children who watch programmes beyond those produced specifically for them.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The Advertising Association		Recommendation 11: Children (p.30-1)	Banning the advertising of foods high in fat, salt and sugar (as determined by the Food Standards Agency nutrient profile) on TV and other broadcast media including new technologies (such as the Internet or mobile phones). There are already rules in place, introduced by Ofcom in 2007, to restrict the advertising to children of products high in fat, salt and sugar (HFSS) in broadcast media. Neither the internet nor mobile phones are broadcast media. The CAP Code, industry's self-regulatory code of practice, sets out specific restrictions for the advertising to children of food and drink products in non-broadcast media. The Code applies to promotional text transmissions (including SMS and MMS), online advertisements in paid-for space (including banner or pop-up ads and online video ads), viral ads, paid-for search listings, preferential listings on price comparison sites, in-game ads, advergames featuring in-game ads, ads transmitted by Bluetooth, ads distributed through web widgets and online sales and prize promotions. Cont…	As indicated above, the final guidance recommends the extention of current advertising scheduling restrictions to 9pm.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The Advertising Association		Recommendation 11: Children (p.30-1)	Developing standards, supported by legislation, to provide controls for non-broadcast media. The Advertising (CAP and BCAP) Codes contain, since 2007, specific rules on food advertising to children. Compliance with the advertising codes is extremely high (virtually 100%). Self-regulation is robust and the most workable method. The advertising industry is acutely aware of the importance of safe, responsible standards and the ASA advertising self-regulatory system is robust, effective and independently administered. The CAP code it administers is binding on all parties. It is by no means voluntary. Self-regulation is clearly the best approach to regulating advertising as it is quick, flexible and responsive to public concerns	The PDG feel that developing equivalent standards, supported by legislation, to regulate non-broadcast media are needed to adequately protect children.
The British Dietetic Association		Section 4. Recommendation 1 - common agricultural policy	Agree with changes in CAP.	Thank you. This is now recommendation 8.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Dietetic Association		Section 4 Recommendation 2 - Labelling	BDA supports FSA integrated label and has responded to recent FOP labelling consultation. This consultation asked for comments on which foods groups should be included in a FOP labelling scheme. The BDA believes that composite foods should have FOP labelling but that labelling of single item foods can be confusing to the public – the exception to this may be for cheese. The opportunity to restrict advertising in line with 'red and amber' products will depend on the outcome of this consultation and recommendations from the FSA as to which products should carry a FOP label. Restricting product advertising on the basis of the FOP label needs a nutrient profiling model as used with children's food advertising and not judged simply on one red or amber 'spot'. Any scheme restricting advertising of 'less healthy' foods needs to consider how to categorise any advertisement which includes creating a meal from basic ingredients where the nutritional profile of one item (per 100g profile) may be prohibited but when included in a meal with other allowed items and the whole meal is considered, would meet the criteria.	Thank you. This recommendation is now number 6. The bullet point relating to the restriction of advertising of products in the red and amber categories has been deleted.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Dietetic Association		Section 4 Recommendation 3 - salt	Agree with need to reduce salt content of foods and to ensure this is a requirement across the EU. Would want to understand the effect of VAT on culinary standard salt on food costs. There is a danger of increasing food costs for those foods which require added salt which could have a health inequality issues. Agree that voluntary regulations have been a success in reduction of salt in key food items – mandatory legislation may not have any greater effect. Need to explicitly discourage use of low sodium (lo salt etc) alternatives.	This is now recommendation 1. The bullet point relating to VAT on culinary standard salt has been deleted. Bullet point 10 includes an explicit discouragement of the use of low sodium alternatives.
The British Dietetic Association		Section 4 Recommendation 4 Saturated fats	Concerns that these proposed actions will have a disproportionate effect on low income families. Would want to see reformulation of all food products to reduce sat fat before any introduction of VAT on higher fat products. Without this a 'fat' tax will disproportionately increase the cost of foods eaten in low income families. Agree with the reduction of VAT on processed fruit products like fruit juice and smoothies to encourage up take but these are high value items and may have little effect on increasing fruit and vegetable up take in low income families.	This recommendation (now number 2) now encourages the reformulation of all food products to reduce the amount of saturated fat. The recommendation now also says 'create the conditions whereby products containing lower levels of saturated fat are sold more cheaply than high saturated fat products. Consider legislation and fiscal levers if necessary'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Dietetic Association		Section 4 Recommendation 5 - trans fat	Industry is already addressing this issue voluntarily. Emphasis should be on replacement of trans fat with unsaturated fats rather than the current policy of replacing trans fats with palm oil. Agree with recommendations that identify levels for each population group including low income families. Concerns about how to regulate trans fat content in take away foods.	Thank you. This recommendation (now number 3) includes 'encourage the use of vegetable oils high in polyunsaturated and monounsaturated fatty acids to replace oils containing IPTFAs. Saturated fats should not be used as an IPTFA substitute' to address the substitution of IPTFAs with palm oil.
The British Dietetic Association		Section 4 Recommendation 7 - take-aways and other food outlets	Strongly support any development of planning law that restricts fast food outlets/food sales close to schools. Opportunities and mechanisms for implementation need to be clearly explained to allow wide use of such local legislation.	Thank you. This is now recommendation 11.
The British Dietetic Association		General	The BDA support the use of a range of policy options at different levels particularly aimed at improving the diet of younger people where dietary change will have the greatest health benefits.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		General	Reformulation: In 2003, Unilever embarked on its Nutrition Enhancement Programme (NEP), which uses internationally-accepted dietary advice, including World Health Organisation maximum levels of trans fats, saturated fats sugars and salt. Using a single nutrient profile, the entire food and beverage portfolio of over 22,000 products has been evaluated, giving clear direction for nutritional improvements. Since 2005, reformulation against NEP standards resulted in the removal of 30,000 tonnes of trans fat, 27,000 tonnes of sugars, 12,500 tonnes of saturated fat and 3,500 tonnes of sodium from across the global portfolio. In the UK, a number of brands have undergone significant reformulation as part of the programme. Salt levels have been reduced on average by 30% since 2003 in all soups and sauces (Knorr, Chicken Tonight, Knorr Ragu and Colman's); the Lipton Ice tea range has 10% less sugar; and I Can't Believe It's Not Butter has 22% less saturated fat and 16% less salt.	Thank you. The final guidance acknowledges the role of industry in reducing risk of CVD to date.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		General	*Reformulated products being cheaper*: This is not always possible as ingredients are sometimes replaced with more expensive products or new technologies may be required. Time is required for their re-development. Re-labelling costs must also be considered.	Thank you.
Unilever UK Ltd		Single risk factors: 3.19	*Key CVD risk factors:* What about cholesterol, high blood pressure, diabetes?	This paragraph (now 3.2) has been clarified to say 'key risk factors that can be modified..'. These factors exert an influence on CVD through, among other things, cholesterol, blood pressure and diabetes.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		General, 3.22, 3.23, 3.38	Recommendations should be based on a **whole** cardioprotective dietary approach which includes: • A wide variety of foods • plenty of fruit and vegetables (at least 5 portions a day) • plenty of starchy foods eg bread, pasta, rice, potatoes, cereals (wholegrain where possible) • lean meat and lean meat products, poultry, eggs, beans, pulses • fish twice a week (of which one portion should be oily) • low fat dairy products such as skimmed or semi-skimmed milk, lower fat cheese, cottage cheese, yogurts • 'good' fats such as sunflower, olive, rapeseed, linseed oil (and margarine and spreads made from them) nuts and seeds • less 'bad' fats such as butter, lard, fatty meats and meat products, cakes, pastries, biscuits, snacks, chocolates etc. Cont…	Agreed. The importance of a 'healther' diet is emphasised in sections 3.32-35

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		General, 3.22, 3.23, 3.38	• cholesterol lowering foods such as oats, plant sterols, pulses (beans and lentils), almonds, soya, fruit and vegetables containing soluble fibre[1] • less salt • maintenance of energy balance to prevent weight gain ***References*** *1. Jenkins et al JAMA Vol.290 No.4.July 23,2003*	See resonse above

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.24 Trans Fatty Acids (TFAs)	The guidance focuses on the effects of TFAs formed industrially by partial hydrogenation and ignores the effects of natural (ruminant) TFAs from meat and dairy foods, implying that they are 'safe' or at least not harmful and yet there is no scientific basis to separate their health effects. At high levels of consumption, TFAs are detrimental regardless of the source. The recent Scientific Update from the World Health Organisation (WHO) on TFAs states that *"limited evidence indicates that industrial and ruminant TFAs may have similar effects on serum lipoproteins when ruminant TFAs are consumed at sufficient quantities".*[1] In the UK, the current consumption levels of TFAs have fallen from 2.1% of food energy in the mid 90s to only 1% of food energy in 2007 mainly due to voluntary measures taken by the food industry to reduce the level of TFAs in foods, particularly from the margarines and spreads industry. TFA intake at a population level is now half of the recommended maximum TFA intake of 2% food energy and is not considered a major public health concern by the Food Standards Agency (FSA) and The Scientific Advisory Committee on Nutrition (SACN) in a report they made to the UK health ministers in 2007.[2,3] Cont…	IPTFA are discussed in the considerations section in paras 3.44-48. While the PDG is aware that there is 'limited evidence' on the difference in effect between ruminant and industrial TFAs it is important to bear in mind that there is more scope to modify the levels of IPTFAs in food where these are part of the manufacturing or cooking proceses. The final guidance acknowledges the progress made by industry and the FSA in reducing the overall levels of IPTFA consumed. However the PDG remain concerned that some groups are consuming IPTFAs at higher levels. The recommendation (recommendation 3) is intended to ensure that all groups of the population are protected from the adverse effects of IPTFA. The PDG is aware that saturated fat represents an area for action, and recommendation 2 addresses this.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.24 Trans Fatty Acids (TFAs)	Trans fats are found naturally in meat and dairy produce (3-8% of the total fat content) and these fats make up an estimated 35-45% of the total TFA dietary intake in the UK.[2] (Intake of trans fats differs from country to country and is much higher in for example the United States and Denmark.) Meat and dairy produce are also main contributors to saturated fat intake. The average saturated fat intake in the UK is 13.3% of food energy and is 20% higher than the Department of Health's recommendation of 11% food energy for good health. Therefore focussing on reducing intakes of saturated fat rather than trans fat should be the priority for cardiovascular public health benefits. ***References*** *1. European Journal of Clinical Nutrition (2009;63;S1-S75)* *2. Food Standards Agency Trans Fatty Acids Executive Summary 13 December 2007http://www.food.gov.uk/multimedia/pdfs/board/fsa071207.pdf* *3.Update on trans fatty acids and health – position statement by the Scientific Advisory Committee on Nutrition 2007 http://www.sacn.gov.uk/pdfs/sacn_trans_fatty_acids_report.pdf*	Please see response above

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.25 Substituting low-fat for high-fat products Pg 26 Recommendation 4: saturated fats	It is unnecessary to reduce saturated fat from 14% to 6% of energy (as in Japan). The Food Standards Agency launched its saturated fat campaign to help prevent cardiovascular disease in February 2009. It included recommendations by The Scientific Advisory Committee on Nutrition (SACN) which recommends that people should consume no more than 11% of energy as saturated fat on average. This advice is based on recommendations from an independent advisory committee[1] and is in line with World Health Organisation (WHO) recommendations on reducing the risk of diet and chronic disease.[2] Reducing saturated fat to 6% of energy as in Japan would also be unrealistic and unpalatable for the UK culture and cuisine. The American Heart Association Step II diet for lowering cholesterol in high risk individuals recommends 7% of energy from saturated fat as an intensive therapy if the Step 1 (10% of energy from saturated fat) fails. Only the most motivated individual could keep to this regime for any length of time even with a large amount of support from a health care professional and is, in our opinion, an unsustainable approach for use in the general population.	As the comments above indicate, it is important to reduce population level consumption of saturated fats. The recommendation indicates that there are potential benefits from going beyond the current target. Para 3.8 notes that 'the recommendations made in this guidance are not intended to replace existing advice to the public on diet. Rather, they will support the next stage of policy development to tackle the substantial burden of ill health from CVD and other chronic diseases' The recommendation addressing saturated fats is now recommendation 2.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.25 Substituting low-fat for high-fat products Pg 26 Recommendation 4: saturated fats	The total dietary fat intake does not have to be reduced in the UK. The fat intake is almost at the population recommended target intake of 35% of food energy.[3] It is the fat quality that is more important than the quantity. The evidence is that replacing saturated fat with polyunsaturated fat is most beneficial in preventing cardiovascular disease[4] which is supported by the latest FAO/WHO expert consultation background paper.[5] Evidence shows that replacing saturated fat with carbohydrates i.e. a low fat diet, is not as effective in reducing cardiovascular disease risk as replacement with polyunsaturated fatty acids. [4,5] Cont…	Para 3.41 notes that 3.41'the PDG discussed the benefits of substituting mono-unsaturated or polyunsaturated fats for saturated fats'
Unilever UK Ltd		3.25 Substituting low-fat for high-fat products Pg 26 Recommendation 4: saturated fats	This guidance should place more attention on the importance of polyunsaturated fatty acids – both omega-3 and omega-6 fatty acids. The heart health benefits of omega-3 and omega-6 have recently been assessed by the European Food Safety Authority (EFSA). EFSA concluded, as part of the EC Regulation on Nutrition and Health, that a cause and effect relationship has been established between the dietary intake of omega-6 (linoleic acid) and omega-3 (alpha-linolenic acid) and the reduction of blood cholesterol levels.[6] Recommended intakes for polyunsaturated fats (omega-3 and omega-6) suggest they should make up 6-10% of food energy to provide adequate intake for optimal health.[2]	

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.25 Substituting low-fat for high-fat products Pg 26 Recommendation 4: saturated fats	***References*** *1. Department of Health. Nutritional aspects of cardiovascular disease.1994.HMSO London.* *2. .WHO/FAO Joint WHO/FAO expert consultation "Diet, Nutrition and the prevention of chronic diseases". WHO Technical report series 916 2003 Geneve* *http://www.who.int/nutrition/topics/5_population_nutrient/en/index12.html* *3. Henderson L, Gregory J, Irving K et al (2003).The National Diet and Nutrition Survey: Adults Aged 19-64 years, Volume 2: Energy, protein, carbohydrate, fat and alcohol intake. HMSO,London.* *4. Jakobsen et al. Major types of fat and risk of coronary heart disease: a pooled analysis of 11 cohort studies. American Journal of Clinical Nutrition. First published ahead of print February 11,2009 as doi10.3945/ajcn.2008.27124.* *5. C.Murray Skeaff & Jody Miller, Ann Nutr Metab 2009; 55:173-201* *6. EFSA Journal 2009,7(9):1252*	

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Unilever UK Ltd		3.39 Plant sterols and stanols	A large body of scientific evidence of more than 170 studies has proved that plant sterols and stanols significantly lower cholesterol. The European Commission (EC) and the European Food Safety Authority (EFSA) have recently confirmed the cholesterol lowering efficacy of plant sterols by formally granting approval of the disease risk reduction claim for plant sterols.[1] "Plant sterols have been shown to lower/reduce blood cholesterol. Blood cholesterol lowering may reduce the risk of coronary heart disease." This claim is one of the first to pass the tough new Disease Risk Reduction (DRR) claims process, introduced by Europe. Extensive scientific and clinical evidence dossiers were submitted to support these health claims linked to reduce risk of disease and approved by the rigorous and independent scrutiny of the EC and EFSA. ***Reference:*** *The European Food Safety Authority Journal 2008 781, 1-12*	The PDG felt that plant sterols and stanols may help reduce CVD. However, there was concern over the potential impact on inequalities and so the PDG did not make a practice recommendation. However, para 3.74 identifies this as an important topic, and it is the subject of a research recommendation (see section 5 in the final guidance)

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.39 Plant sterols and stanols	2-2.5g of plant sterols taken daily reduces blood cholesterol by 10%. The table in Annex 1 shows the most cost effective way to deliver 2g plant sterols from the Flora pro.activ range of foods. The most cost effective way is to use Flora pro.activ spread which works out at **25-27p a day** (less than the price of a newspaper) and we consider affordable by most.	Thank you. Please see response above.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		Rec 2: product labelling and marketing & Rec 6: catering guidelines	In the current UK debate on front of pack (FOP) labelling, Unilever endorse the findings of the multi-stakeholder Public Health Commission (PHC) report, "We're all in this together – Improving the long-term health of the nation". The PHC proposes a consistent approach should be used to increase the provision of nutrition information on food sold in both retail and out-of-home (OOH) settings. This will help support the aim of delivering positive consumer behaviour change through improved public health education, articulated in a consistent and compelling way through all available channels and over the long-term. The PHC propose that this should cover food served in both the public and private sector and in so doing give consistent nutrition information everywhere.	These recommendations are now numbers 6 and 10. To support consistent labelling, recommendation 6 now says 'establish the Food Standards Agency's single, integrated, front-of-pack traffic light colour-coded system as the national standard for food and drink products sold in England.' Recommendation 10 includes the assessment of the Healthier food mark and the development of a programme for its implementation if found effective. Labelling on menus (including calorie content) is part of the criteria for this mark.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		Rec 2: product labelling and marketing & Rec 6: catering guidelines	As the PHC proposes, the provision of nutrition information can be extended as follows : • For consistency, consumers should have exposure to nutrition information in a simple and consistent approach wherever they are. • We acknowledge that there is no one system that perfectly fits this extended scope, however front of pack labelling and point of choice OOH setting should provide calories, sugars, salt, fat and saturated fat. Information should include Kcal (for calories) and grams (for other nutrients) per portion against agreed GDAs. • Should business wish to provide further nutrition evaluation of this information such as colour coding and text, this should be on a voluntary basis and in applicable categories, in addition to the agreed standard baseline.	Please see response above

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		Rec 2: product labelling and marketing & Rec 6: catering guidelines	The colour-coding / text system recommended by the FSA for use on FOP labelling has been designed using a nutrient profile which applies to 7 food categories. There are significant issues in extending this beyond its designed remit e.g. Olive Oil having the same colour coding / text as Lard; Margarine having the same colour-coding Butter, despite large differences in magnitude of saturated fat levels (one of the FSA's current areas of focus for consumer education and consumption targets). Given Unilever's support for the PHC proposal that nutrition information be extended as widely as possible across food consumed in the UK, we estimate more than 75% of food currently being consumed is not being considered by current FSA nutrition information schemes. This is based on colour coding / text being applicable to around 10% of supermarket food consumed (based on estimate of applicability to 12% of food sales) and OOH calorie information designed for maximum of 15% food consumed (based on 1 in 6 meals being consumed out of home).	Thank you for this interesting information. The PDG feel that the FSA single, integrated, front-of-pack traffic light colour-coded system is the current best option and that it should be established as the national standard in England.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		Rec 2: product labelling and marketing & Rec 6: catering guidelines	Unilever propose that consumers should have exposure to nutrition information in a simple and consistent approach wherever they are and whatever they are eating. We believe that the 75% of food not covered by FSA nutrition information schemes could be addressed by increasing the penetration of baseline information covering calories, sugars, salt, fat and saturated fat. Information should include Kcal (for calories) and grams (for other nutrients) per portion against agreed GDAs. Unlike colour-coding and text, GDAs are factual nutrition information and do not require a nutrient profile. As a result, while colour-coding and text can only be accurately applied to 10% of foods consumed, GDAs can be applied to all foods.	Thank you. Please see response above.
Unilever UK Ltd		Rec 2: product labelling and marketing & Rec11: children	*Restrict advertising for products that fall into amber and red categories of the FSA food labelling scheme*: There appears to be confusion between the FSA labelling scheme that is used for front of pack labelling and the FSA/OFCOM nutrient profiling scheme that restricts the foods that can and cannot be advertised to children. The schemes are designed for different purposes and one should not be used in place of the other.	Thank you. The bullet point referring to advertising of products in amber and red categories has been deleted.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		3.26, 3.27 & Rec 3:salt	The report acknowledges that salt consumption has successfully fallen by 0.9g over the last 5 years. This has been achieved through voluntary measures within the food industry. We support the continuation of this approach without further regulatory action. In the UK Unilever supports the FSA work on salt. It also has a global salt strategy in place to reduce salt across the entire food portfolio. By reducing the amount of salt in the food we produce we can contribute to achieving dietary intakes of 2400mg of sodium (6 g of salt) per day by the end of 2010 and 2000mg sodium per day (5 g of salt) by the end of 2015. These levels are recommended by many national governments (6 g per day) and the World Health Organization (5 g per day) respectively.	Thank you. The final guidance acknowledges the progress made by industry. This recommendation is now number 1.
Unilever UK Ltd		3.26, 3.27 & Rec 3:salt	In the period 2003 – 2008, Unilever has already removed almost 9 100 tonnes of salt from our products, without affecting taste or cost. Thanks to our unique combination of skilled chefs and technical R&D expertise, coupled with our scale – we sell more than 30 000 product lines in over 100 countries – we are uniquely well placed to help raise awareness of the benefits of a healthy, lower salt diet. Every day, 320 million people – some five per cent of the world's population – will eat a meal based on Unilever food products.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		Recommendation 5: trans fats	The recommendation to 'eliminate trans fats altogether from the national diet' is impractical and again only refers to the trans fats from industrial partial hydrogenation sources. It ignores the trans fats which occur naturally in meat and dairy produce which make up an estimated 35-45% of the total trans fat intake in the UK diet.[2] Action by the oils and fats industry has already reduced trans fats from industrial partial hydrogenation sources to a minimum but it is not possible to completely remove all trans fats from vegetable oils as standard oil refining processes result in trans fat formation at low levels < 1%. **What action could be taken?** • Replace trans fatty acids with vegetable oils high in polyunsaturated and monounsaturated fatty acids. Ensure saturated fats are not used to replace trans fats. This action is confusing and should read 'replace trans fatty acids *in partially hydrogenated vegetable oils/foods* with vegetable oils high in polyunsaturated and monounsaturated fatty acids. Ensure that reformulation of foods to reduce trans fats, does not increase saturated fat levels in the diet'.	The final guidance clarifies that this recommendation (number 3) refers to industrially produced trans fatty acids (IPTFA). It acknowledges the progress made by industry (and in other counties), however the PDG are concerned that some groups in the population may consume higher levels. The aim of the recommendation is to ensure that all groups are protected from the effects of IPTFA.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unilever UK Ltd		Recommendation 5: trans fats	**References** 1. European Journal of Clinical Nutrition (2009;63;S1-S75) 2. Food Standards Agency Trans Fatty Acids Executive Summary 13 December 2007http://www.food.gov.uk/multimedia/pdfs/board/fsa071207.pdf 3.Update on trans fatty acids and health – position statement by the Scientific Advisory Committee on Nutrition 2007 http://www.sacn.gov.uk/pdfs/sacn_trans_fatty_acids_report.pdf	Thank you.
Unilever UK Ltd		Recommendation 11: children	*Develop standards, supported by legislation, to provide controls for non broadcast media*: We do not believe that there is a need to further restrict food advertising beyond those already implemented by OFCOM. The implementation of the OFCOM restrictions has been effective to date and further restrictions for non broadcast media, based on a voluntary agreement amongst government and industry would be a better approach.	This recommendation (now number 4) aims to provide protection for children from advertising. It includes an extension of the scheduling restrictions of HFSS foods up until 9pm
Unilever UK Ltd		General	What is the most cost effective way to deliver 2g plant sterols daily? – see Appendix 1.	As indicated above, the final guidance contains a research recommendation about plant sterols (see section 5)

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		1 – Rec 1	The common agricultural policy (CAP) is the overarching framework used by European Union member countries to form their own agricultural policies. However, it introduces a number of significant distortions, including on certain food prices in the EU. Ongoing reform of the CAP should remove such distortions and provide a basis for supporting other government action on preventing CVD in the UK. There is sufficient evidence to suggest that the CAP could now be reviewed to support the prevention of CVD. The evidence suggests that the following are among the measures that could be considered. ***What action could be taken?*** • Negotiate to amend the common agricultural policy (CAP) to ensure it takes account of public health issues. Specifically, food growing and production should be linked to healthy eating guidelines, such as the 'Eatwell plate[4]'. • Negotiate to ensure the European Commission's (EC) impact assessment procedure (part of its strategic planning and programming cycle) takes the effect on cardiovascular health into account.	This text has been amended and is now recommendation 8

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		1 – Rec 1	• Ensure fiscal incentives and disincentives for industry support the production of low saturated, as opposed to full-fat, dairy products and fruit, vegetables and cereals for human consumption. • Ensure reduced-fat dairy products are cheaper than their full-fat equivalents. [1] Food Standards Agency (2007) Eatwell plate [online]. Available from www.eatwell.gov.uk/healthydiet/eatwellplate	This text has been amended and is now recommendation 8

Consultation on the Draft Guidance – Stakeholder Response Table

Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		1 – Rec 1	**Question 1a**: To what extent is the content of this recommendation already being used in the food industry (e.g. the use of fiscal incentives and disincentives)? UB is in favour of policies that support the availability of ingredients at competitive prices and welcomes reform of the CAP. All activities would be expected to conform to competition law. **Question 1b:** Is it feasible to ensure that reduced-fat dairy products are cheaper than their full-fat equivalents? N/a **Question 1c**: What measures may be needed to ensure that reduced-fat dairy products are cheaper than their full-fat equivalents? N/a **Question 1d:** To what extent is work already being done in this area? N/a **Question 1e:** Can you please provide any other comments on this recommendation? N/a	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 2: product labelling and marketing	A framework of legislation and regulation affects consumer behaviour. The evidence suggests that, in the context of product labelling and marketing, the following measures could be considered. ***What action could be taken?*** • Develop legislation to implement the Food Standards Agency's Integrated Label for products sold in England. This includes traffic light colour-coding, text to indicate 'high', 'medium' or 'low' content of particular ingredients and the percentage guideline daily amount (GDA). Implement the system in advance of legislation. • Restrict advertising for products that fall into the amber and red categories of the Food Standards Agency's food labelling system. • Clearly label products requiring a high salt content (such as some cheeses and meat products) to indicate that they are high in salt and should only be considered for occasional consumption.	This text has been amended and is now recommendation 6

Consultation on the Draft Guidance – Stakeholder Response Table

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 2: product labelling and marketing	**Question 1a:** How feasible is it for retailers and manufacturers to adopt the FSA's traffic light system for labelling products sold in England? There is currently a EU proposal to amend labelling legislation, therefore any changes to UK labelling and the timescales will be driven by this. From a cost and resource perspective it would not be feasible to amend labelling prior to this and then be expected to change labelling again through EU legislation. UB uses GDA labelling, along with most of Industry. Research does not support an integrated labelling model over other existing models (FDF commissioned review of FSA research). The integrated model mentioned in the recommendation has not been tested for this purpose so its effectiveness is unknown. **Question 1b:** How would the restrictions in advertising products in the amber and red categories of the FSA's food labelling system be implemented and managed? Is this feasible to introduce? What would the impact be on businesses?	The amended recommendation in the final guidance aims to ensure that the Food Standards Agency's single, integrated, front-of-pack traffic light colour-coded system is established as the national standard for food and drink products sold in England. It also says 'ensure the UK continues to set the standard of best practice by pursuing exemption from potentially less effective EU food labelling regulations when appropriate'. The bullet point referring to restrictions on advertising of red and amber categories has been deleted.

Consultation on the Draft Guidance – Stakeholder Response Table

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 2: product labelling and marketing	The FSA Traffic Light model was not designed for this use. Ofcom already has a model for limiting advertising of high fat, salt, sugar products to children. Restricting advertising on red and amber products using the FSA Traffic Light model would lead to confusion and conflict with the existing Ofcom model. It would mean some manufacturers could not advertise their products, which would have a huge business impact. The model limits choice by restricting red and amber products but also by recommending mainly green products. It could actually divert those on a balanced diet onto a less well-balanced diet. Again this is demonizing certain foods as bad rather than looking at the overall content of the diet and its balance. It should be noted that restrictions in advertising will not only impact the food industry but other industries would also need to be consulted on these recommendations e.g. TV and advertising industries.	The bullet point referring to restrictions on advertising of red and amber categories has been deleted

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 2: product labelling and marketing	**Question 1c:** What aspects of this recommendation are already being used in practice in England? A wide number of manufacturing companies are using GDAs to indicate %s of nutrients and their contribution to daily nutrient requirements. It should be used in conjunction with Government food based guidelines, such as the Eatwell plate, 5 a day, 2 fish per week one of which is oily etc, to ensure a balanced diet is being achieved. Businesses are already focused on reducing salt, saturated fats and sugars in products through other initiatives such as the FSA SFEI programme and due to their own consumer research. **Question 1d:** How does this recommendation support existing work in this area? See answer to 1c. **Question 1e:** What impact may this recommendation have on the sale of products with high saturated fat, trans fat and salt content? The inability to advertise would have a significant impact on sales, particularly for new products. This could stifle innovation. Companies are already reformulating products but changes need to be made gradually so that consumers can adapt to different tastes.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 3: Salt	High levels of salt in processed food have a major impact on the total amount consumed by the population. This, in turn, can cause high blood pressure which is a CVD risk factor. Industry has made considerable progress in reducing salt in everyday foods. However, the rate of progress is too slow and, as a matter of priority, needs to be accelerated. The evidence suggests that the following are among the measures that could be considered to reduce salt content further. ***What action could be taken?*** • Reduce population salt intake to no more than 6g per day initially (and to a lower level in the longer term). This can be achieved by promoting the benefits to the EU and introducing national legislation. • Continue to reduce the salt content of commonly consumed foods (bread, meat products, cheese, soups and breakfast cereals) by persuading manufacturers to progressively change their recipes and production methods. All food products available throughout the EU should be subject to these changes, including low cost, standard and luxury goods.	This text has been amended and is now recommendation 1

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 3: Salt	• Agree EU salt targets for processed foods. Ensure salt levels are monitored in commonly consumed foods. Monitoring should take place at EU level and nationally. • Reinforce national targets for salt intake among the population and review them at regular intervals. This includes developing a timetable to meet the voluntary targets on the level of salt used in common foods. Set a deadline for the development of mandatory regulations if progress is not being achieved. • Develop fiscal incentives and disincentives to encourage manufacturers to make low salt products cheaper than their higher salt equivalents. • Impose VAT at the standard rate on culinary quality salt, as part of a consistent policy to ensure taxation is used to reduce the risk of CVD.	This text has been amended and is now recommendation 1

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 3: Salt	**Question 1a:** What would the impact of this recommendation be on the formulation of foods with high salt content? The UK FSA and EU already have salt reduction programmes in place which industry is working towards on a voluntary basis. The FSA has identified targets by product category based on sodium levels that present significant technical challenges. There are several ingredients that contribute to sodium levels: - added salt (sodium chloride) - raising agents (sodium bicarbonate) - flavouring components (monosodium glutamate, sodium diacetate) Within UB products (biscuits, savoury snacks and cakes) much of the added salt has already been removed in a programme started in 2004 and the sodium contribution from other ingredients has also been substantially reduced.	The recommendation (number 1 in the final guidance) acknowledges the progress made on reducing salt content of foods.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 3: Salt	UB has achieved significant reductions across its biscuits and cakes portfolio. For example McVitie's HobNobs have reduced in salt by 60% (sodium – 40%) and McVitie's Digestives by 51% (sodium – 27%). UB has achieved a 18% sodium reduction across the crisps and snacks portfolio e.g. Hula Hoops achieved a 31% sodium reduction and Skips a 27% sodium reduction. Progress to date has been achieved relatively quickly through phased stages. The UK programme has been in place for some time, therefore, legislation would not speed up this process UB would question what evidence there is to show a health benefit by further reducing the GDA below 6g/day. **Question 1b:** What work is being done in this area and will the recommendations support this work? (e.g. phasing out the use of salt, replacing salt and monitoring salt levels). The UK FSA is monitoring and evaluating progress in this area with its self-reporting framework and additionally has introduced achievements tables for industry to complete.	The recommendation (number 1 in the final guidance) acknowledges the progress made on reducing salt content of foods. Evidence linking lowering salt intake and blood pressure with health benefits is set out in the expert papers linked to the recommendation (see appendix c)

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 3: Salt	**Question 1c:** Is it feasible for manufacturers to make low salt products cheaper than high salt products? Are these types of cost saving measures achievable and realistic? This is unlikely because salt is a relatively cheap ingredient and whatever is used to replace it during reformulation will be more expensive. **Question 1d:** What impact may this recommendation have on health inequalities (e.g. will this recommendation improve the diet of those in more deprived areas that are more reliant on cheaper food sources that may contain high levels of salt). It would be necessary to carry out retrospective and prospective epidemiology surveys to establish this. History would suggest a more in depth education programme is needed rather than simply reformulating products. As these products are unlikely to be cheaper (as discussed in Q1d) cost is likely to be prohibitive to those in deprived areas. Cont…	Thank you. As indicated in 3.17 the PDG feel that individually based interventions such as education run the risk of increasing inequalities because of the addional difficulties associated with making lifestyle changes for those in disadvantaged groups.
		Rec 3: Salt	**Question 1e**: Are the standards and targets suggested in this recommendation achievable? The FSA revised 2010 and 2012 salt targets are very challenging. The functional role of salt and/or sodium (i.e. raising agents) in products and the technical difficulties need to be taken into account.	Thank you. There are no doubt technical difficulties in reformulating products but this can bring substantial health benefits.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 4: saturated fats	Halving the average intake of saturated fats (from 14% to 7% of total energy) might prevent approximately 30,000 CVD deaths annually. The evidence suggests that the following are among the measures that could be considered. ***What action could be taken?*** • Offer subsidies to encourage manufacturers to make low saturated fat products cheaper than the higher saturated equivalent. • Introduce legislation (for example in relation to VAT) to make high saturated fat products more expensive than the lower saturated fat equivalent. • Introduce legislation (for example, in relation to VAT) to make fruit and vegetables and other foods that make up a healthy diet cheaper than less healthy products. • Reformulate all products (particularly those sold as low priced 'value' ranges) to reduce the amount of saturated fat they contain and remove trans fats.	This text has been amended and is now recommendation 2

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 4: saturated fats	**Question 1a:** What would the impact of this recommendation be on the formulation of foods? Which sectors of the food industry would be affected most from this recommendation? Firstly this recommendation goes a long way beyond the requirement of the COMA recommendations and WHO recommendations. Again industry is already working towards saturated fat reduction in products. There is an FSA Saturated Fat and Energy Intake programme already underway. An FSA consultation for biscuits and cake has recently closed. A consultation on snacks is expected in Autumn 2009. From November 2008 UB has been reducing the saturated fat content of three of its leading McVitie's biscuit brands. McVitie's Digestives, McVitie's Hob Nobs and McVitie's Rich Tea contain 50% less saturated fat. In 2009 UB reduced saturated fat content in a number of products such as Jacobs Cream Crackers, Go Ahead Crispy Fruit Slices, which ranged from 30% to 50%. In 2010 saturated fat levels in Digestives, Rich Tea and Hob Nobs will be further reduced.	The final guidance acknowledges the progress made in reformulation. However, the PDG feel there is further work to be done to reduce the consumption of saturated fats, and that benefit can be gained from reducing saturated fat intake beyond the current recommendation. Para 3.8 notes that 'the recommendations made in this guidance are not intended to replace existing advice to the public on diet. Rather, they will support the next stage of policy development to tackle the substantial burden of ill health from CVD and other chronic diseases'

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 4: saturated fats	UB have been reducing saturated fat content in savoury snacks since 2005. Some UB savoury snacks already have approximately 80% less saturated fat than in 2005 e.g. Hula Hoops and Skips. Again further reductions are due in 2010. **Question 1b:** What impact would the reformulation of value food products have on their content and the cost of production? Would it still be possible to sell these products at low prices? At the current time it would not be feasible to make these products cheaper. A great deal of investment, time and resource is needed to research and implement such changes. It is worth noting that reducing saturated fat in products would not necessarily lead to a reduction in calories or total fat.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 4: saturated fats	**Question 1c:** Is it feasible for manufacturers to make lower saturated fat products cheaper than higher saturated fat products? Are these types of cost saving measures achievable and realistic? Reductions in saturated fats are often achieved by changing fat blends, which are significantly more expensive than traditional oils and fats. However, to implement such changes requires a great deal of background work to be carried out prior to making the changes. UB has the capability to manufacture 6 types of sweet & savoury biscuits with reduced levels of saturates. This capability is currently within 4 manufacturing sites across UK & Northern Europe and covers 9 plant lines out of a total of 82. The ability to do this took three years to complete at a cost of £7m. Across 10 sites producing biscuits, UB makes approximately 250 product types and has many more different recipes.	Thank you

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 4: saturated fats	Each product change would need to be developed on each individual product with trials, research and shelf life tests, requiring substantial resource and cost. The changes would then need to be implemented in the factory(s), which will require further significant resource to cover additional commissioning factory trials, ingredient on-costs and the capital costs associated with the product changes. The capital costs are largely associated with procuring new oil tanks and handling equipment. Tanks are required to be positioned within the manufacturing site. In some circumstances, there is limited space to accommodate this new equipment. Any additional resource required to support the reduction of saturated fats would be in addition to the technical, sales, marketing, manufacturing, procurement and packaging originations resources required to support the ongoing needs of UB. **Question 1d**: Is it feasible and achievable to make fruit and vegetable and other foods that contribute to a healthy diet cheaper than less healthy alternatives? Would reductions in VAT be sufficient to achieve this?	Thank you.

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United Biscuits Ltd		Rec 4: saturated fats	**Question 1e:** Can you please provide any other comments on this recommendation? It should be taken in to consideration that manufacturers and retailers are already working towards reducing saturated fat in products and are also currently responding to FSA consultations on targets for SAFA, sugars (and salt).	Thank you. The final guidance acknowledges the progress made on these issues.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 5: trans fat	Trans fats constitute a significant health hazard. As part of the proposed CVD prevention framework, it would be beneficial to eliminate them altogether from the national diet. The evidence suggests that the following are among the measures that could be considered. ***What action could be taken?*** • Ban the use of industrial trans fats for human consumption throughout the EU. • Revise the current UK and international recommendation on trans fatty acids, so that they account for less than 0.5% of daily energy value for **all** groups – not just for the population mean. Develop a timetable for action that includes the introduction of legislation if there is no other way to achieve this in a timely fashion. • Replace trans fatty acids with vegetable oils high in polyunsaturated and monounsaturated fatty acids. Ensure saturated fats are not used to replace trans fats.	This text has been amended and is now recommendation 3

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 5: trans fat	• Independently monitor the level of trans fats in processed and take-away food to identify consumption in all sectors of the population, rather than relying on an average figure.	This text has been amended and is now recommendation 3
United Biscuits Ltd		Rec 5: trans fat	**Question 1a**: What would the impact of this recommendation be on the formulation of food products in your organisation (e.g. would you have to reformulate food products)? Which sectors of the food industry would be affected most by this recommendation and why? UB began the process of removing hydrogenated vegetable oil (a source of TFAs) in 2004. This has been an ongoing reformulation programme with the result that all products manufactured by UB in the UK do not contain hydrogenated vegetable oil. The UK FSA has acknowledged there is no need for any further action on TFAs as industry has already acted voluntarily. It should be noted that TFAs occur naturally in ingredients such as butter and cheese.	Thank you. The PDG is pleased that products mafactured by UB in the UK no longer contain IPTFAs. The aim of this recommendation (now number 3) is to ensure that all groups in the population are adequately protected from IPTFAs

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 5: trans fat	**Question 1b:** Within manufacturing of food what work is being done to phase out the use of trans fats, replace trans fats and monitor trans fats? Similarly what work is being done for caterers within takeaway establishments? See answer to 1a **Question 1c:** Is it feasible for local authorities to monitor the level of trans fats in processed and takeaway foods? How could this be performed? **Question 1d:** What impact may this recommendation have on the diet of those in more deprived areas that are more reliant on cheaper food sources (e.g. low socio-economic groups and those from the Asian community who have a high prevalence of CVD)? The Government would need to research and evaluate this. In time the new rolling NDNS programme may give an indication on this.	Thank you.
United Biscuits Ltd		Rec 5: trans fat	**Question 1e:** Are there issues with replacing trans fats with other fats (e.g. unsaturated fats)? How long would it take to phase out trans fats and are there replacements for trans fats? What would the impact be on the taste of food and its shelf life? Already removed as per Q1a.	Thank you.

United Biscuits Ltd		Rec 10: commercial interests	Food and drink manufacturers and retailers have a particularly important role in helping to prevent CVD. Some responsible commercial organisations are already taking positive action. The evidence suggests that the following are among the measures that could be considered. **What action could be taken?** • Introduce a similar framework for food and drink production to that adopted by the World Health Organization for tobacco control (that is, 'Framework convention on tobacco control' [2003]). • Develop an international public health information system (resembling GLOBALink5) for CVD prevention. • Ensure all meetings, including lobbying, between the food and drink industry and government and government agencies are conducted in a transparent way. • Ensure disclosure rules are followed including declarations of interests (for example, on past employment and consultancy work).	This text has been amended and is now recommendation 5

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 10: commercial interests	**Question 1a:** How would it be feasible to introduce a "framework for food production"? What would be the main barriers and facilitators for this? This would need to be looked at from a EU perspective. UK industry are already working on reformulations with the FSA and as a result of consumer feedback that they want healthier products. **Question 1b:** To what extent is this recommendation already being followed (e.g. transparency of meetings and prevention of lobbying)? Industry and the FSA are already engaged in consultations on many aspects of these recommendations. An increased focus should be given to consumer education on lifestyle and diet and utilising initiatives such as Change for Life. Cont…	Thank you. This guidance is aimed at producing population level recommendations for prevention of CVD.
United Biscuits Ltd		Rec 10: commercial interests	**Question 1c**: What support will be needed to successfully implement this recommendation? The draft recommendations require re-evaluation, therefore, it is not possible to comment on this at this stage.	Thank you. In line with usual practice, the draft recommendations have been reconsidered in light of stakeholder comment and fieldwork.

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United Biscuits Ltd		Rec 10: commercial interests	**Question 1d:** Can you please provide any other comments on this recommendation? The EU Health and Nutrition claims regulation has a significant impact on what manufacturers can say about products. UB markets a range of reduced fat biscuits and crackers, such as McVitie's Light Digestives, McVitie's Light Rich Tea and McVitie's Light Hob Nobs, which are 30% less fat than the standard products. The impact of the Commission decision on whether permanent reduction claims are subject to the nutrient profiles will mean that the McVitie's Lights range & Jacob's Light Cream Cracker may have to be withdrawn from sale (depending on the outcome of the discussions on nutrient profile thresholds).	Thank you. This guidance does not address EU health and nutrition claims.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
United Biscuits Ltd		Rec 10: commercial interests	Currently the EC Nutrition & Health Claims Regulation has no provision for temporary reformulation claims such as the "Now 50% less saturated fat, same great taste" message that was used in the McVitie's Digestive advertising. Unless resolved by the Commission, this will potentially limit the amount of reformulation work carried out by manufacturers and will certainly limit the amount of marketing and advertising spend. UB fully supports the position that a 10% reduction should be the minimum required in order to make a reformulation claim and that this must be without reference to a nutrient profile. UB has made a considerable investment in reformulation since 2004, of approximately £20 million. The ability to communicate these improvements is essential to encourage manufacturers to invest in product reformulations and to encourage consumers to switch to healthier alternatives.	Thank you. This guidance does not address EU health and nutrition claims.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
University of Bath		General	It seems that second hand smoke (SHS) may have been somewhat overlooked as a risk factor for CHD. There is now: • Considerable evidence from large cohort studies (including BRHS with cotinine as a biomarker) that SHS increases the risk of CVD. • Growing evidence that reducing exposure (following smokefree legislation) reduces acute coronary events. While many of the early studies evaluating smokefree legislation used before/after analyses that will have overestimated the impacts (largely by failing to account for the underlying secular decline in CHD events), more recent studies provide more robust evidence and a number or reviews are now available. • In vitro and in vivo evidence linking SHS exposure to CV and endothelial dysfunction including a longitudinal study in children showing exposure to SHS increases endothelial dysfunction (even at moderate levels) in a similar way to that seen in adults.	Thank you. The PDG felt that in view of the fact that a number of NICE guidance documents have addressed tobacco use it would not be covered in the guidance. The revelant published NICE guidance documents are referenced, and the national tobacco control measures set out in 'beyond smoking kills' are endorsed (see para 3.3 and 3.4). It is likely that NICE will receive additional topics relating to tobacco. Referrals can be found on the 'public health guidance in development' page of our website (http://www.nice.org.uk/guidance/phg/indevelopment/index.jsp?d-16544-p=1).
University of Liverpool		General	This is a superb draft; it would appear to be (in the making of) the most significant and well-researched article of public health advice yet issued by NICE.	Thank you.

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University of Liverpool		3.31 Children	It is commonly held (especially by many nurses) that the diet of small children should include full fat (some accept semi-skimmed) milk. Yet other studies should the early onset of atheroma in the arteries of teenagers killed in RTAs. Could the PDG carry out a review of the science: do children really require high fat milk, if they are eating otherwise a healthy diet (Japanese children do not drink milk!)? The high levels of saturated fat eaten by UK children come first and foremost from dairy products (with beef in second place). If skimmed milk provides no hazard to small children, this would support efforts to reduce the mean population LDL cholesterol level. If high fat milk is needed in such children, how about soya milk instead (with its healthier fat profile)?	Thank you. Unfortunately it is not possible for the PDG to carry out this review.
University of Liverpool		4, Recommendation 1	This section on the CAP as the first recommendation is welcome. But could it not provide more detail on the CAP reforms needed? These are summarised the publication from the Faculty of Public Health: "A CAP on Health?"	Thank you. This recommendation is now number 8 and has been amended.

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UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	The UKCPA and RPSGB welcomes this guidance and wishes to develop and promote the role of pharmacy in this area of public health	Thank you.
UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	Community Pharmacists as part of the new community pharmacy contractual framework are required to deliver a range of essential services that includes public health advice that includes provision of information and advice in the form of leaflets and other media, participation in health promotion campaigns and signposting enquiries to other agencies when appropriate. Pharmacy has played a prominent role in the prevention of cardiovascular disease through promoting smoking cessation and weight management.	Thank you.
UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	Certain pharmacists are trained and accredited to provide advanced services such as Medicine Usage Reviews (MURs). These provide an opportunity for pharmacists to promote healthy lifestyles to patients, particularly in the area of cardiovascular disease prevention.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	PCTs can commission community pharmacies to provide enhanced services. These include smoking cessation advice and provision of treatment, weight management and provision of treatment, diagnostic testing and screening e.g. Blood Pressure, Blood glucose.	Thank you.
UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	The Darzi Review, published in 2008, has identified pharmacists as being one of a range of health care professions that will be commissioned by PCTs to provide NHS health checks from 2009 onwards. This will have the advantage of joining up all the enhanced services that have been commissioned to prevent cardiovascular disease as well as providing a framework in which all participating professions work together for the benefit of the patient.	Thank you.
UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	One final point, community pharmacies are the most accessible part of the NHS in view of their location, hours of service and availability of advice and information. Furthermore they see customers who are well and those who are ill.	Thank you.

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UK Clinical Pharmacy Association & Royal Pharmaceutical Society of Great Britain		general	Hospital pharmacists also make a valuable contribution to prevention of cardiovascular disease and its progression. A number of pharmacists have moved into advanced practice in Specialist or Consultant posts. They can also prescribe if suitably accredited. They make an important contribution to health outcomes through the provision of information advice given to patients and healthcare professions and their involvement in Pulmonary Rehabilitation sessions for patients.	Thank you.
Westminster City Council		General	Thank you for the invite to attend a fieldwork review workshop on 21st October, and for this opportunity to help with your review of how the council and the Planning system can provide support the prevention of cardiovascular disease. The council has a number of long established policies to create an attractive public realm encourages people participate in more physical lifestyle and create a better environment the council welcomes the opportunity to be involved in your project. Please find below our responses to the recommendation and questions you raised.	Thank you.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council	See Appendix 3 for map of locations of hot food takeaways and schools	Recommendation 7 and 12: Take-aways and other food outlets	Food from take-away and other outlets comprises a significant part of many people's diet. Local planning authorities are able to control fast-food outlets and it is up to them to use their powers to take effective local action. Regulation of the outlets selling this food would provide another opportunity to tackle the risk of CVD. The evidence suggests that the following are among the measures that could be considered. **What action could be taken?** Ensure local planning authorities understand existing legislation which enables local authorities to refuse planning permission for take-aways and other food retail outlets in specific areas (for example, near schools). Ensure the legislation is widely implemented. Use existing powers to set limits for the number of take-aways and other food outlets in a given area. Directives could specify the distance from schools and the number that can be located in certain areas.	These recommendations are now numbers 11 and 23.

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Wednesday 14th October – 16th November

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 7 and 12: Take-aways and other food outlets	Westminster's adopted Unitary Development Plan already provides a comprehensive policy approach on this issue. Policies SS6 District Centres and SS7 Local Centres contain criteria which could be used to resist / refuse new non - A1 uses (this includes A5 uses hot food take-aways) if these uses are seen to have a detrimental affect on the character and function. These policies seek to enhance the vitality and viability of district centres and the provision of services in local centres, strengthening the character and function of these centres. To enable a proposal for a non-A1 use to be accepted by the Council, it would need to demonstrate that it would not: - have a detrimental impact on the viability or character or function of a centre, frontage or parade, - have a detrimental effect on the environment or residential amenity, - Unacceptably intensify an existing use or existing concentration of uses and - jeopardise the long term A1 use of the ground floor.	Thank you. This is a useful example of what can be done.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 7 and 12: Take-aways and other food outlets	This policy criteria is important in Westminster as it ensures that a residential amenity is protected. Westminster is a densely populated with a range of uses, where residential and commercial uses exist creating vibrant and attractive places where people live and work. The diverse mix of uses contribute to the character of this world city, therefore creating a balance of activities is essential. The dense range of uses in areas in a compact are encourages walking. This policy approach has protected the concentration of non-A1 uses in district and local shopping centres. This policy approach has been in place since 2007 and has been effective at controlling the location of non – A1 uses. Westminster City Council is in the process of drawing up a new collection of documents which will guide future development. These documents form a folder of documents called the Local Development Framework (LDF) which will guide the development of Westminster over the next 20 years. Cont…	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 7 and 12: Take-aways and other food outlets	The City Management Plan forms part of the LDF it will contain detailed policies to replace those detailed above. The LDF is holistic in its policy approach with recognition that planning has a key role in influencing the wider determinants of health through improvements to the physical environment. We work closely with our colleagues in Westminster PCT / NHS Westminster on joint strategies and the LDF. In developing new policies an assessment was made of the distribution of hot food take-ways and the Council is considering if it could strengthen the existing policy approach and limit the number of take-aways. The London Borough of Waltham Forest has an adopted policy in its UDP that relates to restaurants, cafes, drinking establishments and hot food take-aways, this is supported by a Supplementary Planning Document. This approach is seen as best practice by some health professionals a similar approach is being considered for the City Management Plan.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 7 and 12: Take-aways and other food outlets	The plan attached shows the location of hot-food takeaways within 400m (10 minutes walking distance) of schools or youth clubs and parks in Westminster. In Waltham Forest the SPD recommends that no hot food take-ways should be permitted in a 400m radius of these facilities. When this approach is applied in Westminster nearly all areas are excluded from providing hot food take-ways, this is without a 400m boundary being drawn around the royal parks (Regents Park, Kensington Garden, Hyde Park, Green Park and St James Park). If this was drawn in there would there only be very small pockets where these uses are permitted. These would be in the North West, small pocket in south and around Oxford Street. Oxford Street is one of Westminster's International Shopping Centres therefore A5 Take-away uses are unacceptable as these uses could erode the vitality of this area. While North Westminster is one of Westminster's key regeneration areas with some significant health inequalities, therefore the council would not support a concentration of these uses in these areas.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 7 and 12: Take-aways and other food outlets	The Council will continue its work on policy development in this area, however from the evidence provided it realises that using a blanket approach to restrict further take-aways and food outlets would not be effective as there are already several across Westminster. Perhaps it is more important to try and influence the type of food sold in hot food takeaways. • *Link this legislation to licensing and food hygiene regulations.* • *Introduce bye-laws to regulate the opening hours of take-aways and other food outlets near schools.* In order to manage take-aways and other food outlets through licensing legislation and food hygiene regulations it would be necessary to extend the scope of licensing objectives. Central government has the responsibility for changing licensing objectives through legislation. This would allow intervention and give more control to local authorities to manage opening hours of these uses without the need to introduce bye-laws.	Thank you. The aim of these recommendations is to highlight the opportunities open to local authorities to address these issues. Local circumstances will be very important. Recommendation 23 also includes 'help owners and managers of take-aways and other food outlets to improve the nutritional quality of the food they provide. This could include monitoring the type of food for sale and advice on content and preparation techniques'.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Question 7 & 12 a	What might the barriers be to limiting take-aways and other food retail outlets in specific areas? Despite a strong policy approach the market will continue to drive demand for rentals and uses. This means the City Council cannot fully control the change of use of individual units, as unlawful changes of use will occur when leaseholders / landowners change uses to secure an increase in profits or rental values.	Recommendation 11 also includes 'review and amend 'classes of use' orders for England to address disease prevention via the concentration of outlets in a given area'.
Westminster City Council		Question 7/12b	How would this approach compare to existing planning policy and practice? The strengthening of policy may restrict some additional take-aways or hot food outlets being developed. However, it does not control the types of food being sold in existing units. Lifestyle choices and the demand for fast -food plays a significant part in ensuring that these uses remain viable and increase within Westminster. Therefore education about the food and the impact of a poor diet are the key to reduce demand for these uses.	Thank you. As indicated above, recommendation 23 also addresses the nutritional quality of food provided in take-aways and other food outlets.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Question 7/12c	Are there any further changes that would be needed to enable LA planning committee to implement this recommendation? All policy changes are subject to rigorous consultation policies and considered by internal committees. Therefore political support is required at the local and national level to ensure that public health becomes a consideration in planning decisions. Securing political support in this way may be problematic as there are may priorities and considerations in planning applications.	Thank you. As noted in the introduction to the recommendations, 'the final decision on whether these policy options are adopted – and how they are prioritised – will be determined by government through normal political processes'.
Westminster City Council		Question 7/12d	What impacts might this recommendation have on the diet of those individuals in low socio - economic groups and high risk groups (e.g. Asian community)? Strengthening current policy and practice alone is unlikely to have a measurable impact, a combination of factors that influence the health of these groups. Education and lifestyle choices are play a key role in improving the diet of low social economic and high risk groups.	Paras 3.16-18 indicate that both population level and individual level interventions have a role to play in addressing CVD. The focus of this guidance is on population level interventions.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Question 7/12e	Can you please provide any other comments on this recommendation The government's change4life campaign promotes a healthy diet and encourages adults and children to adopt a healthy lifestyle. To supporting these initiatives central government, could implement an initiative that seeks to ensure that healthier options are provided by take-aways and food outlets. Restricting new uses will not address the problem which exists. Trading Standards and the food standards industry have could ensure foods are of good quality and nutritionally balanced.	Thank you. Recommendation 23 also includes 'help owners and managers of take-aways and other food outlets to improve the nutritional quality of the food they provide. This could include monitoring the type of food for sale and advice on content and preparation techniques'.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 8: Active Travel	Travel offers an important opportunity to help people become more physically active. However, inactive modes of transport have increasingly dominated in recent years. The evidence suggests considering the following measures. **What action could be taken?** Use fiscal incentives and disincentives to promote physical activity including physically active travel to and at work. For example: • Exempt VAT on sports and exercise equipment, cycles and related equipment used at work • Place direct taxes on the provision of car parking used as a benefit. The City Council does not control VAT on sports and exercise equipment, this is a matter for consideration by central government. However, the Council like other private sector organisations can support employees cycling or walking to work through a range of incentives.	Thank you. This recommendation has been amended. Recommendation 15 now includes reference to NICE guidance on promoting physical activity in the workplace. Recommendation 21 also addresses the promotion of physical activity.
Westminster City Council		Question 8a	From previous experience have schemes such as exempting VAT from sports equipment been successful in increasing active travel? See point above.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Question 8b	*Would placing taxes on the provision of car parking have a negative impact for those individuals that may need to use these for other means (e.g. disabled, working mum that needs to drop off her children prior to work).* There would need to be political support before taxes are applied to car parking in Westminster. There is not likely to be support for this approach. The Blue Badge scheme provides all disabled people with two hours free parking. In light of these existing arrangements it would not be acceptable for central government to introduce a tax for this group which often have no choice but to use their own transport.	Thank you. Recommendation 9 now says 'consider and address factors which discourage physical activity, including physically active travel to (and at) work. An example of the latter is subsidised parking The impact of schemes'. Implementation of schemes would need to address the needs of groups such as those who are disabled.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Question 8b	At present all drivers allow 10 minutes to drop off or collect passengers. This approach encourages short journeys. However, a policy decision by central government could be to reduce drop off and collection times this would act as a disincentive for drivers. To be successful the government should put investment into a range of alternatives that support these target groups (like parents and guardians taking children to school) to make more trips locally by bike or on foot. The standard drop off time should still apply to those with disabilities as they are less mobile and need this time to be able to move across London. Westminster City Council currently supports schools by providing road safety advise. This includes risk assessments of roads, providing lessons and resources to help children cross roads safely training teachers and classroom assistants on how to manage crocodiles of small children. The Council also provides at a cost cycle training to children in school. In some areas in Westminster the school crossing patrol officers also play a key role helping children and parents cross busy roads.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		*Question 8c*	*Please describe any other schemes that you are aware of that have been successful in increasing sustainable active travel?* Westminster City Council provides employees with cycle allowance and boots to encourage cycling and walking to work. The council in partnership with the London Borough of Camden and Transport for London offer Doctor Bike checks and free adult cycle training for local people and staff. This has been successful at encouraging more people to cycle around the city. These sessions are available for a fee by the council to local businesses. 'A walk to work' photographic competition was held two years ago with incentives, this was to encourage more people to walk to work. 'In town without my car' encourage everyone to adopt a bike for a day. Cont….	Thank you for these useful examples.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		*Question 8c*	Officers in the Council took part in a cycle to work challenge during June and July this year. The challenge was sponsored by Transport for London and will be promoted further this year. The Council came 30th out of 300 businesses in London. The council will seek to introduce more events of this nature to encourage active travel. Potential Schemes - the Council is looking to set up a Cycle to Work Scheme has received support across the council and is likely to be implemented. The Council is considering a scheme which will allow all employees to make savings on a new bike and safety equipment. The "tax break" allows you to obtain a brand new bike hired from your Employer which is free from Tax and NI. This can save up to 50% on the cost of the bike and equipment. Employees contribute a small amount of their salary on a monthly basis over 12 or 18 months and receive a bike and accessories which enable them to commute to work. The council recognises that using a bike for travel to and from work and while at work will improve health, save money, protect the environment and mean officers can get to sites quickly. Cont…	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		*Question 8c*	The council is looking to pay corporate membership to the Mayor of London's cycle hire scheme. This should allow staff to use bikes for work purposes. Some local authorities also provide a few Brompton bikes for officers to use for journeys to and from work and out on site. There is political obtaining a fleet of Brompton for officers. More support from employers to encourage people to walk to work	Thank you.
Westminster City Council		*Question 8d*	What are the main barriers and facilitators for this recommendation? One of the main barriers is a lack of funding for projects. A wide range of ideas exist to encourage active travel just not enough resources to support these ideas.	Thank you. Recommendation 21 says 'apportion part of the local transport plan (LTP) block allocation to promote walking, cycling and other forms of travel that involves physical activity in line with growth targets for the use of these modes of transport' (check final wording)'
Westminster City Council		Recommendation 9 and 13 : Health Impact Assessment (policy and practice)	Health impact assessment is a well-developed method of determining the likely health consequences of particular policies, initiatives or actions. It is important to ensure this approach is applied as a routine part of the policy development process. The evidence suggests that the following are among the measures that could be considered.	These recommendations are now numbers 7 and 22.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 9 and 13 : Health Impact Assessment (policy and practice)	***What action could be taken?*** • Assess all public policy for its potential impact (positive and negative) on cardiovascular disease and other related chronic diseases. In addition, assess its potential impact on health inequalities. Assessments should be carried out using health and policy impact assessment and other similar, existing tools. • Assess the potential impact (positive and negative) that all local plans will have on rates of CVD and related chronic diseases, including any potential impact on health inequalities. Use existing tools such as health impact assessments.	

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 9 and 13 : Health Impact Assessment (policy and practice)	The City Council uses a Health Impact Assessment as part of the policy development process for the LDF. These are not used for planning applications in Westminster. Westminster HIA toolkit was designed in partnership with Westminster PCT it is detailed in its approach but does make not specific reference to CVD. In most cases these tools can only be used to assess the impact on the wider determinants of health not on specific diseases as it is difficult to say a particular policy change in isolation can impact on a person's health. In reality a range of policies will impact on a persons overall health. • Make health impact assessments mandatory for all public policy. Monitor the outcomes of policy following the assessment and use them to follow up and amend future plans.	Thank you for this interesting information.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 9 and 13 : Health Impact Assessment (policy and practice)	If Health Impact Assessments are to be made mandatory there would need to be guidance and a consistent approach across local authorities. At present the planning system requires a Sustainability Appraisal (SA) to be carried out on policies and it is best practice to provide Equality Impact Assessments (EIA) and Health Impact Assessments (HIA). These processes add to the production time in developing policy. To streamline and create a more holistic assessment process the Council suggest work is undertaken at central government level to develop Integrated Impact Assessments.	Thank you.
Westminster City Council		Question 9/13a	*How would this approach compare to existing policy and practice on health impact assessments?* Streamlining assessments would speed up the process of assessing plans and policies. Looking at issues falling out of EIA, HIA and SA together will same time will help to identify key issues of concern.	Thank you.
Westminster City Council		*Question 9/13b*	*What are the implications of implementing health impact assessments on all public policy?* These assessments do take time to produce, however they do provide a useful way to check to see if a policy is creating healthy environments.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 17: Local and Regional Policy	***What action should they take?*** • *Align Section 106 funding ('planning gain') with the promotion of heart health to ensure there is funding to support physically active travel and to give people in disadvantaged areas access to affordable fruit and vegetables.* Planning Obligations are used to mitigate the social, economic and environmental impacts of development. Central government guidance on planning obligations is set out in ODPM Circular 05/05. This states that planning obligations must always meet the following five tests which are: • relevant to planning • necessary to make the proposed development acceptable in planning terms • directly related to the proposed development • fairly and reasonably related in scale and kind to the proposed development; and • reasonable in all other respects.	Thank you. The bullet point referring to supporting active travel has been moved to recommendation 21. The reference to access to fruit and vegetables has been deleted.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 17: Local and Regional Policy	In light of this it would be difficult to use planning obligations to secure funding for s106 agreements for active travel as it would be difficult to relate travel to a particular development. Therefore asking for contributions towards active travel is not appropriate. Westminster's Supplementary Planning Guidance was adopted in 2008 this document does support active travel. The document makes contributions to CCTV, Public Realm and Open Space as it provides improvements to the physical environment which will improve encourage people to adopt healthier lifestyle and walk or cycle to work and in directly make a contribution towards active travel. S106 agreements will often seek to provide supporting social and community facilities to support the needs of new communities. There is now a more flexible approach to social and community facilities, which support a range of uses, designing facilities in this way will allow these facilities to be used by a range of groups and continue to be an asset for local communities.	Thank you. The PDG is aware of a number of s106 agreements that have supported active travel.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Recommendation 17: Local and Regional Policy	Planning obligations are not required to secure affordable fruit and vegetables. Instead planning policies can be put in place which would support existing street markets (as detailed in Policy SS13 street markets and individual trading pitches) policies for allotments or community gardens. Westminster's emerging LDF will provide support for all of these uses to encourage people to learn about and grow their own food.	Thank you. The reference to access to fruit and vegetables has been deleted
Westminster City Council		Question 17a	*How does the content of this recommendation differ from existing planning policy and resourcing provision?* New policies may be added to the policy framework but this will not require extra resources.	Thank you.
Westminster City Council		*Question 17b*	*What else will need to be done to implement this recommendation (e.g. how will the schemes be run in disadvantages areas?)* In developing policy officers will discuss the approach with a range of key stakeholders. It is the community and these key stakeholders that will implement and ensure local street markets are improved, new allotments and gardens are developed.	Thank you.
Westminster City Council		*Question 17c*	*What are the main barriers and facilitators for the implementation of the recommendation?* Stakeholders who are involved in these projects can also be seen as barriers as well as facilitators.	Thank you

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Rec 18: Physical Activity	• *Ensure cycle tracks are part of the definitive map (the legal record of public rights of way).* In Westminster all cycle routes are mapped. Transport for London (TfL) works closely with the local authority to ensure that these routes are accurate and provides investment into these routes and new signage. • *Prioritise the needs of pedestrians and cyclists over motorists when developing or redeveloping streets.* This draft guidance suggests that the responsibility for prioritising the needs of pedestrians and cyclists lies with the Local Authority. In Westminster, the Council and TfL will work together to maintain routes and ensure that routes are easy cyclists to use. The City Council seeks to ensure that pedestrian routes are integrated into all schemes to create safe and permeable public realm which encourages physical activity. Cycle parking and ensuring cycle routes are considered in larger developments and across the public realm in Westminster. The Council is also working with Legible London to improve wayfinding across the city through improved signage encouraging people to people to walk shorter distances. Cont…	This recommendation is now number 21. The PDG is aware that the planning system in London has a number of differences with the rest of the country.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Rec 18: Physical Activity	In the workshop session held on the 21st October it was suggested that perhaps local authorities could re allocate part of the budget for road building to promote walking, cycling and other forms of travel that involves physical activity. Altering road layout is important to the provision of better cycle routes, the responsibility for the provision of cycle lanes is not the responsibility of the council this is the remit of TfL and the Greater London Authority who make investment decisions about road design and revised layouts. • *Make it mandatory for public sector employers to provide staff with workplace travel plans incorporating physical activity. Make it a voluntary option for other large employers.* • *Allocate part of the budget for road building to promote walking, cycling and other forms of travel that involves physical activity.*	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		Rec 18: Physical Activity	Parking for car sharing schemes, cycle parking and the Mayor's cycle hire points are supported in the planning application process for large companies. Westminster is working on strengthening its existing travel plan to implement further measures to encourage more sustainable travel choices and active travel. The introduction of mandatory plans will assist in encouraging more active travel. • *Audit and abolish bye-laws that prohibit physical activity in public spaces.* The audit of sites would be straight forward as local authorities hold details of open spaces in accordance with PPG 17 Planning for Open Space. Abolishing byelaws would need political and community support. Investment would be needed to ensure that there is provision of appropriate space to enable a range of play facilities and equipment to allow children and adults of all ages to engage in physical activity. If open spaces are part of residential estates local communities and would need to be involved in agreeing to develop these spaces.	Thank you

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		*Question 18a*	*What physical activity interventions have been effective in your area in increasing total physical activity levels in the population?* In Westminster participation levels are well above the average for London and England 25.1% of people regularly participating in sport and physical activity. This compares with and London average of 21.3% and national average of 21.0%. The development of City Academies, Building Schools for the Future and Big Lottery Fund schemes have provided high quality facilities for sport within the community have provided opportunities to raise the quality of community sport and physical activity for school pupils and the wider community. These facilities have helped to fill the gaps in provision. This alone is not enough as this is not just about provision of facilities but encouraging people to make lifestyle changes and choices. It is recognised that more needs to be done to encourage those who are active to do more and influence others. Working with communities in the deprived wards in the City to ensure that they feel included and able to participate in activities is important.	Thank you.

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Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Westminster City Council		*Question 18a*	Future activities - Encouraging elderly groups to engage in physical activity is a key challenge the council is to find the right kind of 'active place' in a safe environment is particular challenge. The use of alternative attractive and accessible 'active places such as parks and open spaces and community halls are therefore key for attracting elderly residents to be more physically active. The council is looking at the opportunities for activities in open spaces including active recreation, formal and informal sport and organised walks.	Thank you.
Westminster City Council		*Question 18b*	*What would need to be done to audit and abolish bye-laws that prohibit physical activity in public spaces?* An audit of different council's open space strategies would provide an overview of the existing open spaces, their use and the quality of the open space provided. Central government support for this approach is essential, alongside lobbying at the local level to secure political support.	Thank you.

Appendix 1 – Unilever UK Ltd

What is the most cost effective way to deliver 2g plant sterols daily?

value scale (top is best value)		portion size	daily serving	pack size	cost per pack	servings per pack	cost per serving	cost per daily serving
	spread (light)	10g	30g	500g	£4.25	50	8.5p	26p
	spread (light)	10g	30g	250g	£2.24	25	9.0p	27p
	spread (olive)	10g	30g	500g	£4.19	50	8.4p	25p
	yogurt mini-drink	100g	100g	7x100g	£4.15	7	60p	60p
	milk drink	250ml	750ml	1000ml	£1.49	4	37p	£1.11
	yogurt	125ml	375ml	4x125ml	£2.09	4	52p	£1.56

NB: These costs per pack are based on RRP from 30th October 2009 – source Unilever price list

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Appendix 2 – Servier Laboratories Ltd - References

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Appendix 3 – Westminster City Council