National Institute for Health and Care Excellence

Obesity (update)
Scope Consultation Table
27 Nov 2013 – 11 Dec 2013

ID	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
2	SH	Association for Dance Movement Psychotherapy	1	4.3	We are surprised not to see any inclusion of psychological approaches to the management of obesity. Whilst we acknowledge that Binge Eating Disorder may require separate consideration, there is an inevitable overlap with obesity. Research in Dance Movement Therapy (Meekums et al., 2012) suggests that psychological approaches that also focus on the body – like Dance Movement Therapy – can have a positive effect on both emotional eating and weight loss, as well as underlying psychological conditions. This research has also been included in a recently published meta-analysis (Koch et al., 2013).	The benefit of exercise was addressed in CG 43. Thank you for your comments. This scope is an update to CG 43. The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. The area of psychological approaches to the management of obesity has not been prioritised for this update.
12	SH	Association for the study of obesity		4.3 a	We suggest there has been considerable examination of the role of "meal replacements" in weight management, particularly maintenance of weight change. Can this be examined in addition to the evidence concerning VLCD's?	Thank you for your comment. We will be addressing the use of very low calorie diets as part of the update of CG43. This is likely to be defined by calorific content rather than type of diet.
15	SH	Association for the study of obesity		4.5.3 h	The use of bariatric surgery in the young is increasing, whether the post treatment care for these patients should differ to those of adults requires evaluation.	Thank you for your comment. We will take the issue you raise to the guideline development group for consideration when formulating the protocol for this review question.
9	SH	Association for the study of obesity	1	3.c	The increase in obesity admissions probably largely reflects the increase in bariatric surgery which is now about 6000 NHS cases per year. Other admissions related to obesity-related complications are likely to be substantially higher than suggested by these figures, such as	Thank you for your comments, this section has been revised and any errors in figures corrected. The figures for bariatric surgery are for England alone.

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				3. d. 3.e	diabetes, however data are unavailable to link these and other admissions to obesity. Doubling is in last 18 years not 8 (1993-2011) Ethnic differences in differences in the BMI when obesity-related complications develop are important. The figures reported do not take ethnically specific cut-off into account so may be misleading. Can clarification be given that the figures reported are for England or the UK as a whole? This would put the guidelines in a more appropriate context.	
10	SH	Association for the study of obesity	2	4.1.1	Unclear why women have been chosen as a specific group, this is in need of clarification. Women of child bearing age are important, they should ideally be of a healthy weight in the peri-conceptual period, to minimise health complications associated with pregnancy. However this is challenging as a majority of women conceive without planning, and adverse effects of obesity in pregnancy occur mostly in the first trimester, prior to the commencement of antenatal care. Evidence for the success of weight management in men is currently under review (Avenell et al, NIHR review forthcoming, and Sullivan & Brown, Centre for Longitudinal Studies, IOE (in press)) have reported men are highly unaware of their own weight status . Suggest both men and women can be justified for inclusion. Can the terms "the young" and "older people" be defined? Smoking cessation has been identified as a time when unintentional weight gain is common and may undermine any quit attempts. People attempting smoking cessation, are often treated in NHS settings and therefore we suggest that they	Thank you for your comments. Women are no longer listed as a special group. With regard to the peri-conceptual period, NICE has published public health guidance on 'weight management before, during and after pregnancy'. While this does not address clinical management we are unaware of evidence in this area and the above addresses weight management in pregnancy. This areas has not been prioritised for inclusion in this update Thank you for information about this study regarding weight management in men it has been noted. With regard to people giving up smoking as a special group, the Guideline Development group will prioritise the groups of people at special risk of becoming overweight or obese and any available evidence for these groups within the topic area will be reviewed and where appropriate separate recommendations drafted.

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					ought to be included as another special group.	
11	SH	Association for the study of obesity	4	4.3	The issue of remission / resolution of diabetes post surgically ought to consider the evidence that this "solution" can be temporary in some cases, depending largely on body weight changes.	Thank you for your comment the content of which has been noted.
13	SH	Association for the study of obesity	4	4.4 a 4.4 c 4.4 d	It is internationally accepted that changes in waist circumference provide additional information on health status to that of weight and BMI up until a BMI 35kg/m^2. Waist measures can also indicate effects of weight management interventions that include a physical activity element. Many researchers also measure depression and well being, as intentional weight loss can alleviate symptoms of depression and improve well-being. We welcome inclusion of glycaemic control and suggest blood pressure should also be included.	Thank you for your comment. The outcomes listed are examples suggested for questions we expect to answer. The list is not exhaustive and will be tailored to the each evidence review. The GDG will take this information into account when prioritising specific outcomes for the included review questions.
14	SH	Association for the study of obesity	5	4.5.1	Those with type 2 diabetes and obese should also be considered in the context of VLCD's for their clinical effects and cost effectiveness This area is of current research interest. There are some concerns that VLCD approach can lead to a worsening of usual dietary habits in the obese, therefore can the evidence of VLCD and "worsening of food habits" be considered. Ideally after food reintroduction components of programmes this may not be of clinical importance.	The effectiveness of VLCD's will be reviewed including its effectiveness in achieving and maintaining weight loss. With regard to people with type 2 diabetes, The Guideline Development Group will prioritise sub-groups such as people with type 2 diabetes for each evidence review. We will take the issues you raise to the guideline development group for their consideration.
16	SH	Association for the study of obesity	6	General comments	The terms diabetes and type 2 diabetes are used interchangeably and should be used consistently throughout.	Thank you. We have amended this throughout the scope documents to provide clarity and consistency.
4	SH	Association of British Clinical Diabetologists	1	4.3.a	ABCD welcomes the inclusion of this topic although notes that many of the studies at present are at the stage of proof of concept and it is	Thank you for your comment the content of which has been noted.

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		(ABCD)			unlikely that definitive guidance will be possible at the present time.	
5	SH	Association of British Clinical Diabetologists (ABCD)	2	4.3.c	ABCD welcomes the inclusion of this topic which dovetails with 4.3.a above. However, it is hard to see how the topic can be covered without reviewing the surgical interventions for obesity as a whole. The surgical management of obesity is a dynamic field and the interventions used change without any clear indication of why. It may be that certain interventions are more effective in controlling diabetes than others. Cost effectiveness could not be evaluated without taking into account the complications and morbidity associated with each of the interventions individually. We suggest that some limited review of the interventions will be required.	Thank you for your comment. Whilst we acknowledge the content of your comment, we believe that it may be possible to review the evidence to identify whether surgical intervention (of whatever type) can impact on the management of new onset type 2 diabetes in obese patients. Future iterations of this guidance may be able to determine the relative effectiveness of the different interventions related to the management of Type 2 diabetes in these individuals. We agree that cost-effectiveness will be an important recommendations and the available evidence in this area or any de novo modelling in this area will be used to inform the GDG recommendations in this area.
6	SH	Association of British Clinical Diabetologists (ABCD)	3	4.3.h	See above (ID 4&5)	Thank you for your comment. We note your comment regarding the status of the evidence in relation to VLCDS. Whilst we acknowledge the content of your comment, we believe that it may be possible to review the evidence to identify whether surgical intervention (of whatever type) can impact on the management of new onset type 2 diabetes in obese patients. Future iterations of this guidance may be able to determine the relative effectiveness of the different interventions related to the management of Type 2 diabetes in these individuals. We agree that cost-effectiveness will be an important recommendations and the available evidence in this area or any de novo modelling in this area will be used to inform the GDG recommendations in this area.
7	SH	Association of British Clinical Diabetologists (ABCD)	4	4.5.2.b	See above (ID 4 &5)	Thank you for your comment. We note your comment regarding the status of the evidence in relation to VLCDS. Whilst we acknowledge the content of your comment, we believe that it may be possible to review the evidence to identify whether surgical intervention (of whatever type) can impact on the management of new

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						onset type 2 diabetes in obese patients. Future iterations of this guidance may be able to determine the relative effectiveness of the different interventions related to the management of Type 2 diabetes in these individuals. We agree that cost-effectiveness will be an important recommendations and the available evidence in this area or any de novo modelling in this area will be used to inform the GDG recommendations in this area.
8	SH	Association of British Clinical Diabetologists (ABCD)	5	general	The role of the endobarrier should be included as a short term minimally invasive procedure which is attracting increasing use.	Thank you for your comment. We have not prioritised a comparative review of the techniques and methods of bariatric surgery at this time. We are aware of the National Institute for Health Research funded By-Band study currently in progress. A comparative review of all interventions may be beneficial after this study reports.
70	SH	British Obesity and Metabolic Surgery Society	1	4.3	What is the evidence that the BMI thresholds in CG 43 still hold eg for diabetes (ref Lakdawala Asian Consensus meeting Obesity Surgery 2010; 20: 929-936 and Dixon IDF Statement Diabet Med 2011; 28: 628-642)?	Thank you for your comment. The recommendations in CG43 related to BMI draw attention to the differing interventions required when considering the needs of some ethnic groups such as Asian people (for example, see recommendations 1.2.2.8, 1.2.3.4). We are aware of the recent NICE guidance PH46: Assessing body mass index and waist circumference thresholds for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK and will consider this and any other evidence from our review when drafting any recommendations for these groups.
71	SH	British Obesity and Metabolic Surgery Society	2	4.3	Is there enough evidence for lowering the BMI thresholds in CG43 by using comorbidity-based criteria for bariatric surgery, with reference to Sjoholm SOS study. Diabetes Care May 2013 vol. 36 no. 5 1335-1340 and Padwal / Sharma EOSS study. CMAJ 2011; 183: 14 E1059-E1066, including adjustment for Asian populations (ref Lakdawala, Dixon above)? This question may already be covered by 4.5.2.	Thank you for your comment. We will consider the issues you raise when developing the clinical question to cover section 4.5.2 of the scope for this update.
72	SH	British Obesity	3	4.3	What is the clinical and cost effectiveness of	Thank you for your comments. This scope is an update

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		and Metabolic Surgery Society			medical weight management clinics in the treatment of patients fulfilling the BMI criteria before referral to a bariatric surgery team?	to CG 43. The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. The clinical and cost-effectiveness of weight management clinics has not been prioritised as part of this update but may be considered in future updates of this guideline.
73	SH	British Obesity and Metabolic Surgery Society	4	4.3	What is the cost effectiveness of revisional surgery?	Thank you for your comments. This scope is an update to CG 43. The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. The cost-effectiveness of revisional surgery has not been prioritised as part of this update but may be considered in future updates of this guideline.
74	SH	British Obesity and Metabolic Surgery Society	5	4.3	Is there evidence that the threshold of BMI 50 for recommending bariatric surgery as a first line option (1.2.6.7 in CG 43) should be lowered?	Thank you for your comment, this update of CG 43 will not be addressing thresholds of bariatric surgery in general. The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. This update prioritises a review of the evidence regarding the role of bariatric surgery in the management of new onset type 2 diabetes in obese people. The findings of this review may have implications for a BMI threshold for surgery in this population.
75	SH	British Obesity	6		What is the evidence that medication such as	Thank you for your comment. The review prioritised for

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		and Metabolic Surgery Society			statins, ACE inhibitors or metformin should be stopped or discontinued after bariatric surgery in patients with type 2 diabetes, given the evidence from the Schauer NEJM 2012 and Ikramodun JAMA 2012 studies where medication was continued after surgery to achieve maximal metabolic benefit?	this update will primarily answer the question as to the role of bariatric surgery in the management of type 2 diabetes of recent onset in people with obesity. This review question may be prioritised in future updates of this clinical guideline but it has not been prioritised at this time.
76	SH	British Obesity and Metabolic Surgery Society	7		Should the IDF criteria for "optimised metabolic state after bariatric surgery" as outlined in the 2011 IDF document (Dixon, above) be accepted as a target after bariatric surgery?	Thank you for your comment and the reference for the Dixon paper. The Guideline Development Group will consider the appropriate criteria against which metabolic state is measured in the obese new onset Type 2 diabetes following bariatric surgery.
77	SH	British Obesity and Metabolic Surgery Society	8		Should fasting insulin be measured pre surgery as a predictor for which patients would have a mortality benefit after surgery as a raised fasting insulin was shown to be the only predictor of mortality in the SOS study.	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time.
78	SH	British Obesity and Metabolic Surgery Society	9		What is the evidence that patients benefit from pre-operative psychological screening or what psychological morbidities should prevent patients from proceeding to surgery?	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time.
79	SH	British Obesity and Metabolic Surgery Society	10		What is the evidence that patients benefit from pre-operative medical screening or interventions? What medical problems should delay patients proceeding to surgery?	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time.

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80	SH	British Obesity and Metabolic Surgery Society	11		What are the failure rates of surgery that should be made available to patients for example how many patients will regain more than half of all the weight they lost over a 5 year period after gastric bypass, gastric banding, sleeve gastrectomy and duodenal switch?	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time.
81	SH	British Obesity and Metabolic Surgery Society	12		Is there a need for more specific guidance on the suitability of adults with learning disabilities for bariatric surgery?	For each topic addressed in the guideline, people with learning difficulties will be included as a sub-group for which we will look for evidence. When evidence is identified and, where relevant, separate recommendations may be made for this group in both adults and children.
85	SH	Cambridge Weight Plan (Cambridge)	1	General	Cambridge strongly endorse the decision by NICE to undertake a partial review of Clinical Guidance 43 (CG43) and, in particular, NICE's acknowledgment that the section covering Very Low Calorie Diets (VLCDs) requires updating.	Thank you very much for your comments.
86	SH	Cambridge Weight Plan (Cambridge)	2	3.2(c)	Cambridge provides a range of weight management programmes, including those based on VLCDs and LCDs. The science and research around VLCDs, their effectiveness and cost-effectiveness, has clearly moved on since 2006, so we strongly welcome the decision to review this guidance. We hope that the review will provide clarity and enable commissioners and others in the public health system to recommend the use of programmes based on VLCDs with greater confidence. We also hope that no geographical barriers to the sources of evidence taken into account during the guideline development process will be imposed,	Thank you for your comment. The GDG will consider all evidence searched for and considered appropriate and as per guidance outlined in chapter 5 of the NICE Guidelines Manual 2012

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					and that relevant scientific work from outside the UK will be considered.	
87	SH	Cambridge Weight Plan (Cambridge)	3	3.2(d)	In April 2013, the NHS Commissioning Board's issued guidance on the commissioning arrangements for complex and specialised obesity surgery. Although welcome, this has done little to clarify who commissions what and there remains a gap between different tiers in primary care. We hope that the updated guidance on VLCDs within CG43 helps to fill this knowledge gap.	Thank you for your comment. Addressing these issues is not part of the update process. We suggest you forward your comments in this regard to national bodies with responsibility for commissioning services such as NHS England or Public Health England as appropriate.
88	SH	Cambridge Weight Plan (Cambridge)	4	4.1.1(b)	The recognition that there are special groups which may benefit from specific, targeted interventions is welcome but we agree that good evidence must underpin this. Furthermore, Cambridge consider that additional relevant diseases should be added to the list, taking into account the inclusion of 'people with type 2 diabetes'. In particular, we would suggest adding 'people with osteoarthritis' and 'people with obstructive sleep apnoea'. In both cases we believe there is good evidence to suggest that these groups should be targeted.	Thank you for your comment. The Guideline Development Group will prioritise the groups of people at special risk of becoming overweight or obese and any available evidence for these groups within the topic area will be reviewed and where appropriate separate recommendations drafted.
89	SH	Cambridge Weight Plan (Cambridge)	5	4.1.2(b)	We agree that VLCDs are not suitable for pregnant women.	Thank you for your comment.
90	SH	Cambridge Weight Plan (Cambridge)	6	4.3(a)	Section 1.2.4 of the original guideline, on Dietary Advice, includes references to both VLCDs and LCDs. For this reason, we believe that any discussions around definitions to be included in the updated guidance should make reference to both VLCDs and LCDs when used as a Total Diet	Thank you for your comment. We agree and have included definitions of VLCD in the scope to be defined by the guideline development group. However, should the definition of VLCD impact on the definition of LCD this will be taken into consideration by the guideline development group.

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					Replacement. We would also like to reiterate that the definition of VLCDs included in Section 1.2.4.32 of the current guidance, of "less than 1000 kcal/day", is not in line with the definition used at EU level. For instance, Regulation (EU) No 609/2013 *on food intended for infants and young children, food for special medical purposes, and total diet replacement for weight control* on defines VLCDs as products containing fewer than 800 kcal.	
91	SH	Cambridge Weight Plan (Cambridge)	7	4.3(b)	Cambridge would suggest that the definition of this area should read *'Pre-operative dietary programmes before bariatric surgery and follow-up care packages after bariatric surgery (in Surgical Interventions, section 1.2.6'* This formulation would reflect the need for the guideline development group (GDP) to take into account the requirements for the specific dietary programmes which patients referred for bariatric surgery would undertake before undertaking surgery. This would help partially address the current issues related to the provision of tier-3 obesity services.	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time. The role of pre-operative dietary programmes has not been prioritised as an area for inclusion in this update.
92	SH	Cambridge Weight Plan (Cambridge)	8	4.3(c)	Cambridge would suggest that the definition of this area should read *'The role of diet, drug and surgical treatment in the management of type 2 diabetes'.* We believe that there is clear evidence for a potential role for formula diet programmes in reversing early diabetes, and this should be taken into account by the GDP.	Thank you for your comment. We do not agree that this should be changed. We have prioritised surgical treatment for type 2 diabetes and obesity but this does not include diet and drug treatments. We agree that diet and reversing early diabetes is an interesting topic but it has not been prioritised in this update. Future iterations of this guidance may address this issue.

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93	SH	Cambridge Weight Plan (Cambridge)	9	4.3(f)	Given that the current Guidance refers to both VLCDs (Section 1.2.4.32) and LCDs (Section 1.2.4.31), we believe that LCDs should, together with VLCDs, be excluded from the areas which will not be updated – if only because a clarification of the definition of a VLCD will impact on the definition of a LCD, and both can be used as a Total Diet Replacement.	Thank you for your comment. We do not agree that this should be changed as LCD has not been prioritised in this update. However, should the definition of VLCD impact on the definition of LCD this will be taken into consideration by the guideline development group.
94	SH	Cambridge Weight Plan (Cambridge)	10	4.4	Cambridge believe that two indicators should be added to the list of main outcomes, which would provide further clarity: g) cardiovascular risk factors in type 2 diabetes h) body composition changes such as fat mass The addition of these categories is important because (i) the cardiovascular complication of diabetes cause huge morbidity and health-care costs and weight loss reduces cardiovascular risk factors and; (ii) since body weight is a crude anthropometric measure studies reporting fat mass loss (which influences inflammatory state) and lean mass retention (which affects basal energy utilisation and subsequent weight maintenance) should be considered.	Thank you for your comment. The outcomes listed are examples suggested for questions we expect to answer. The list is not exhaustive and will be tailored to the each evidence review. The GDG will take this information into account when prioritising specific outcomes for the included review questions.
95	SH	Cambridge Weight Plan (Cambridge)	11	4.5.1(a)	We concur that, without doubt, the key question on this review of VLCDs is whether they are both effective and cost-effective when reducing weight and maintaining this weight loss. We also welcome the decision to review VLCDs as part of follow-up care packages after bariatric	Thank you for your comment. We will take the issues you raise to the guideline development group for their consideration.

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					surgery. It is also worth noting that VLCDs are essential for some extremely obese individuals to enable them to lose weight before becoming eligible for surgery and we would like to see this included in the scope of this review.	
96	SH	Cambridge Weight Plan (Cambridge)	12	4.6	We welcome any review of the economic aspects of different interventions, as this will highlight the cost-effectiveness of VLCDs.	Thank you for your comment.
30	SH	College of Occupational Therapists	1	General	The College of Occupational Therapists feel that further guidance and detail from NICE will be required for specialist obesity services that are mentioned under 1.2.3.8 and again at 1.2.6.1. These services are important both pre and post surgery and are a core component of the changes proposed in "*Measuring up –the medical profession's prescription for the nation's obesity crisis"* (Academy of Medical Royal Colleges 2013, available at www.aomrc.org.uk).	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time. Where appropriate, further detail may be provided in any updated recommendations linked to surgical interventions for people who are obese with new onset Type 2 diabetes.
58	SH	Department of Health	1	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
123	SH	Lifeblood: The Thrombosis Charity	1		We have no specific comments to make on the draft scope guidelines. However, we would like to emphasise the importance of weight control in reducing the risk of developing venous thromboembolism. Obese individuals are invariably immobile, which is a major risk factor.	Thank you for your comment.
36	SH	LighterLife	1	General	LighterLife welcomes NICE's decision to undertake a partial review of 'Obesity' (NICE Clinical Guidance 43 (CG43)), with a particular	Thank you for your comment.

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					focus on the section covering Very Low Calorie Diets (VLCDs).	
37	SH	LighterLife	2	3.1(d)	Lighterlife would like to point out that the doubling is in the last 18 years, not 8 as is indicated in the document.	Thank you for your comment. This has now been corrected.
38	SH	LighterLife	3	3.2(c)	LighterLife is a provider of weight management programmes, one of which makes use of VLCDs. We strongly welcome the decision to review the guidance around VLCDs and the clarity that this will bring for commercial organisations, healthcare providers and patients. The body of evidence underpinning and providing support for the use of VLCDs has significantly strengthened since 2006 and we are pleased to be able to help clearly define VLCDs as well as help address any issues surrounding safety. We also welcome the possibility of providing data showing the effectiveness of VLCDs as well as the sustainability of weight loss as a result of having followed a VLCD.	Thank you for your comment the contents of which are noted. The GDG are able to undertake a call for evidence in any area where they are unable to access evidence to inform their decision making. This is undertaken in line with guidance contained within the NICE Guidelines Manual 2012.
39	SH	LighterLife	4	3.2(d)	LighterLife welcomed the NHS Commissioning Board's April 2013 guidance on the commissioning arrangements for complex and specialised obesity surgery. We wish, however, to highlight the treatment gap at tier-3 of obesity management in primary care, which covers specialist weight management services. We hope that clear guidance on the use of VLCDs will enable providers and commissioners to appropriately fill in this gap.	Thank you for your comment. Addressing these issues is not part of the update process. We suggest you forward your comments in this regard to national bodies with responsibility for commissioning services such as NHS England.
40	SH	LighterLife	5	3.2(g)	The resolution of type 2 diabetes and the	Thank you very much for your comment. As detailed in

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					improvement in diabetes control have also been observed as additional outcomes in patients who have embarked on a VLCD as a treatment for obesity. We hope that a clear assessment of the evidence in this area will be undertaken as part of the consultation in order to appropriately recommend the use of a VLCD in the treatment of obesity and associated co-morbidities.	the scope, section 4.4, measures of improvement of type 2 diabetes will be considered when reviewing the evidence for the clinical and cost-effectiveness of VLCDs in reducing and maintaining weight loss.
41	SH	LighterLife	6	4.1.1(b)	We welcome the recognition that there are special groups which might benefit from separate interventions targeted at them. As such, we look forward to seeing the evidence of the effectiveness of such interventions taken into account by NICE in the future.	Thank you for your comment. The Guideline Development Group will prioritise the groups of people at special risk of becoming overweight or obese and any available evidence for these groups within the topic area will be reviewed and where appropriate separate recommendations drafted.
42	SH	LighterLife	7	4.1.2(b)	LighterLife agrees that VLCDs are not suitable for pregnant women.	Thank you very much for your comment. Pregnant women are excluded in this scope.
43	SH	LighterLife	8	4.3 (b) and 4.53 (c)	Lighterlife believes that during the update of the areas from the original guideline within the context of management, the use of VLCDs due to their nutritionally complete compositional criteria should also be considered in follow-up care packages after bariatric surgery. In addition, both their clinical and cost-effectiveness should be assessed and considered at this time.	Thank you for your comment. The Guideline Development Group (GDG) will prioritise sub-groups and interventions such as VLCD's within care packages following surgery for each evidence review. We will raise the issue you raise with the GDG.
44	SH	LighterLife	9	4.3(c)	Lighterlife believes that in light of the evidence currently available it would be appropriate to also consider the role of VLCDs (alongside that of bariatric surgery) in the management of type 2 diabetes of recent onset in people with obesity.	Thank you for your comment. The Guideline Development Group will prioritise sub-groups and interventions for each evidence review. We will raise this topic with them.
45	SH	LighterLife	10	4.4(a)	Lighterlife believes that in addition to changes in weight and BMI, changes in waist circumference	Thank you for your comment. The outcomes listed are examples suggested for questions we expect to

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					(certainly for people with a BMI <35) should also be included as a main outcome.	answer. The list is not exhaustive and will be tailored to the each evidence review. The GDG will take this information into account when prioritising specific outcomes for the included review questions. We have added waist circumference to the list of proposed outcomes
46	SH	LighterLife	11	4.5.1(a)	LighterLife agrees that the principal, over-riding question regarding the review of VLCDs is that which seeks to establish both the clinical and cost-effectiveness of their use in reducing – and maintaining – weight loss. We believe that this is a crucial aspect of an effective intervention, and for this reason our programmes have a specific focus on providing psychological support, including specific advice on increasing activity, to help people achieve both long-term behaviour change and weight loss maintenance.	Thank you for your comment.
47	SH	LighterLife	12	4.5.2(b)	Lighterlife believes that the effectiveness of VLCDs in the management of type 2 diabetes in those who are obese, should also be considered.	Thank you for your comment. The Guideline Development Group will prioritise sub-groups and interventions such as VLCD's for each evidence review. We will take the issue you raise to the guideline development group for their consideration
48	SH	LighterLife	13	4.6	LighterLife welcomes the review of the economic aspects of different interventions, as this will underline the cost-effectiveness of VLCDs when compared with other commercial weight loss, food-based interventions	Thank you for your comment.
17	SH	Mencap	1	General	Mencap acknowledges the emphasis that this scope consultation has already placed upon learning disability and welcomes the opportunity to comment and support the development of the	Thank you for your comments. We intend to address the needs of people with learning disabilities in respect of the topics which will be covered in the scope. Where appropriate, further detail related to the care of this

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					guideline consultation. Please find some general and more specific comments below. I invite you to get in touch if further details or clarification are needed. "People with learning disabilities are much more likely to be either underweight or obese than the general population. Women, people with Down's syndrome, people of higher ability and people living in less restrictive environments are at increased risk of obesity. The high level of overweight status amongst people with learning disabilities is likely to be associated with an increased risk of diabetes". "There is evidence that people with learning disabilities take less exercise than the general population and that their diet is often unbalanced with an insufficient intake of fruit and vegetables. In addition, people with learning disabilities often find it hard to understand the consequences of their lifestyle on their health, therefore it is not surprising that many adults with learning disabilities are obese and suffer from conditions that are associated with being overweight". A Millennium Cohort study showed that, aged 7, children with learning disabilities are almost twice as likely to be obese as those without. (Source paragraphs 2,3,4: IHaL Health Inequalities Report, 2011) This brief collation of information, of which there is much more, shows that Mencap are justified in their concern that obesity negatively disproportionately affects people with learning	group of people may be provided in any updated recommendations.

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					disability and, again, would like to welcome the fact that this scope consultation has identified that.	
18	SH	Mencap	2	4.3	Areas that will not be covered: Mencap is concerned that the areas being covered are the least relevant to people with learning disabilities. We feel that other guidance needs to be reviewed, with updates made where necessary, specifically: Lifestyle interventions: A review of the current guidelines surrounding lifestyle interventions would be welcomed by Mencap. This is the most relevant and, it could be argued, most important section in relation to people with learning disabilities. People with learning disabilities often need extra help and guidance regarding basic nutrition and when tackling obesity. Surgical interventions: People with learning disabilities are often at a disadvantage when seeking surgery. Mencap would welcome an open and transparent review of the surgical guidance, with a specific focus on people with learning disabilities	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information For each topic addressed in the guideline, people with learning difficulties will be included as a sub-group for which we will look for evidence. Where evidence is available and where it is considered appropriate, separate recommendations may be drafted
84	SH	Neonatal and Paediatric Pharmacists Group (NPPG)	1	4.1.1	We are pleased to see the inclusion of children and young people in the scope for this guideline.	Thank you for your comment.
31	SH	Public Health	1	3.1a	Need to include agreed cut offs for percentiles of	Thank you for your comment. These figures are

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		Department Blackpool Council			children and young people obesity measures	included within CG 43 and have now been added as a footnote to text in section 3.1d to aid clarity.
32	SH	Public Health Department Blackpool Council	2	3.2	Weight Cycling as an issue should be identified (SIGN Obesity Guidelines 115. Feb 2010. section 8.3)	Thank you for your comment. A change in weight is listed as a main outcome (4.4.a) for any interventions. The GDG will consider issues related to the interpretation and impact of this when drafting their recommendations.
33	SH	Public Health Department Blackpool Council	3	4.2 a	Restricting setting to only where NHS care is provided is unhelpful. We should include the wider context of the client.	Thank you for your comment. This guideline updates the clinical sections of CG 43. NICE clinical guidelines are aimed at NHS healthcare professionals and commissioners of NHS services. The NICE Centre for Public Health develops guidance which addresses a wider audience and is undertaking several guidelines which update the public health sections of CG 43. Please refer to the NICE website for more information.
34	SH	Public Health Department Blackpool Council	4	4.5.3 c	Need to define what the follow up care packages after surgery should be (NOF Guidelines?)	Thank you for your comment. We agree and we will take the issue you raise to the guideline development group for their consideration when formulating the protocol for this review question.
35	SH	Public Health Department Blackpool Council	5		General education package for front line staff could be outlined in line with RCP 2013 report	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. In addition, a review of the relationship of weight loss, in particular bariatric surgery to type 2 diabetes has been added to the guideline. Education and training has not been prioritised for this update.
59	SH	Public Health Wales	1	4.1.2	Given the increasing evidence and concerns of the long term health impacts on the child it is	This is listed as related NICE guidance and where appropriate this guidance will be referred to in the full

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					important that the links to NICE 27 (2010) are identified for the reader. It would also be helpful to include guidance on pre-conception and obesity.	guideline.
60	SH	Public Health Wales	2	4.3 (f & n)	Emerging evidence from the National Exercise Referral scheme in Wales suggests that overweight and obese patients awaiting hip and knee surgery have significant health benefits from participation in the programme ranging from better post-operative outcomes to being removed from the surgical waiting lists because of the improvements. Similarly there is increasing pressure on health boards to introduce pre-operative programmes for obese and overweight patients as a condition of inclusion on waiting lists. Could the guidance include evidence based advice on these proposals? There are also a number of chronic condition pathways that include referral to weight management programmes and these could be addressed in the guidance	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time. Pathways for the management of chronic conditions, which include a referral to a weight management programme, are better included within guidance for that specific condition where it will be read by the healthcare professionals responsible for these people.
61	SH	Public Health Wales	3	3.1b 3.1(d) 3.2(f)	If the guideline covers children, should include the epidemiology of childhood obesity in this section There is a strong and statistically significant direct relationship with deprivation in reception age children (CMP Wales). Other literature supports that obesity is related to inequalities in health in childhood and beyond. Should there also be greater emphasis on pre operative assessment Post operatively – guidance should address the level of support that may be required which may	Thank you for your comments. The epidemiology of childhood obesity is covered in section 3.1d. We note your comments related to deprivation and obesity in reception age children in Wales but do not consider this relevant to include in this brief overview of UK epidemiology. The GDG will consider issues related to inequalities in health as part of its consideration and interpretation of the evidence considered and when drafting recommendations. This guideline is an update of CG 43 which will be

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					involve specialist psychological and dietetic input	limited to the clinical topics where new evidence may change recommendations. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time. The guideline update will address post-surgery follow-up. Recommendations drafted in the area of follow-up care after bariatric surgery will be based on a review of the evidence and GDG discussion.
62	SH	Public Health Wales	4	4.5	This may be addressed in guidance under development for adult lifestyle interventions but if not then an important consideration for review is the additional benefit of including structured supervised physical activity as part of any intervention aiming to manage obesity. A significant finding from the evaluation of a large BHF funded project in Gwent is that the addition of such exercise within the programme improves self-efficacy, aids weight management and reduces attrition. There is a strong rational for this considering the population with obesity and their likely physical activity experience.	Thank you for your comment. The scope consulted upon focusses on the clinical elements of CG43 that will be updated. As you allude to, we are aware that the NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: • Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). • Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. • Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. It is possible that these pieces of guidance may address the issues you raise. Please refer to the NICE website for more information.
63	SH	Public Health Wales	5	4.3 & 5	There is increasing recognition of the need for 'level 3' obesity services for children within health services. Health services need support in the form of recommendations and cost effectiveness (shorter-term than QUALY) analyses to enable	Thank you for your comment. Addressing this issue is not part of the update process. We suggest you forward your comments in this regard to national bodies with responsibility for commissioning services such as NHS England.

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					provision. If this is not covered elsewhere.	
64	SH	Public Health Wales	6	General	Can we assume this guidance will acknowledge Welsh data	Thank you for your comment. The introduction has been revised and quotes data for the United Kingdom. It is not possible to quote individualised data for each country that forms part of the UK.
65	SH	Rosemary Conley Food and Fitness	1	3.2.a	A great deal of information and evidence has been produced regarding the effective use of commercial weight loss organisations to support the management of overweight and obese adults. Publications from the Lighten Up Trial in Birmingham have shown that commercial weight loss organisations are a very cost effective solution and are achieving the weight loss and clinical outcomes required. In order to support patient choice we would advocate that clear guidance is issued to Public Health Commissioners advising they commission a choice of commercial weight loss organisations there by offering choice and convenience to patients/service users	Thank you for your comment. This guideline will update some of the clinical practice sections of CG 43. This update will address the clinical and cost-effectiveness of VLCDs in reducing and maintaining weight loss. Once the guideline has been published, the NICE implementation team will aim to address the issues required for successful implementation of the guideline recommendations. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information.
66	SH	Rosemary Conley Food and Fitness	2	3.2.	The weight management pathway is very fragmented – Tier 1 and 2 sit with Public Health, Tier 3 with Clinical Commissioning Groups and Tier 4 with NHS England. Clarification of roles and	Thank you for your comment. We acknowledge the importance of the issues you raise however addressing these issues has not been prioritised for this update process.

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					responsibilities and guidelines regarding integration would be very helpful	
67	SH	Rosemary Conley Food and Fitness	3	3.2	With ownership of Tier 2 Weight Management sitting with Public Health we are observing that tenders to deliver adult weight management are becoming increasing complex. Tenders require the delivery of combined children and adult weight management services e.g. West Sussex County Council or require delivery into very specialist groups of the population (this would involve commercial weight loss organisations having to moving into the area of working with vulnerable adults etc) e.g. Stoke on Trent or sit within a huge lifestyle remit including weight management, smoking cessation, alcohol and drugs management, sexual health, oral health and mental health e.g. Rochdale Local authorities are looking to commission one overriding provider for all these services. We see this as a barrier to entry and in turn this restricts choice and potentially increases costs	Thank you very much for your comment the content .of which is acknowledged. However the provision of detailed commissioning or service guidance is beyond the remit of this partial clinical guideline update.
68	SH	Rosemary Conley Food and Fitness	4	4.2.a	Settings can be outside the NHS (subject to the usual adherence to commissioner requirements)	Thank you very much for your response. This guideline updates the clinical sections of CG 43. NICE clinical guidelines are aimed at healthcare professionals and commissioners of NHS services. The NICE Centre for Public Health develops guidance which addresses a wider audience and is undertaking several guidelines which update the public health sections of CG 43. Please refer to the NICE website for more information.
69	SH	Rosemary Conley Food and Fitness	5	4.3.a	Areas that will be updated GP's to be advised that are able to promote commercial weight loss organisations within their	Thank you for your comment. We will be reviewing the clinical and cost-effectiveness evidence of VLCDs. Recommendations will be drafted based on a review of

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					surgeries They should offer choice and provide access to information summarising the commercial weight loss organisations main principles and classes and costs	the evidence in this area and also be informed by the GDG clinical experience.
101	SH	Royal College of General Practitioners	1	General	The scope is clear and to purpose (PS)	Thank you for your comment.
102	SH	Royal College of General Practitioners	2	General	I welcome this Guideline update which tackles one of the most important issues for the NHS and society as a whole. It is imperative to consider wider public health programmes as well as taxation on sugar sweeted drinks and other foodstuff, availability of cheap fast foods and supermarket behaviour as important levers on reducing the prevalence of obesity. (MH)	Thank you for your comment. We agree that these are important issues, but this guideline updates the clinical practice sections of CG 43. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: • Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). • Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. • Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information.
103	SH	Royal College of General Practitioners	3	General	Most of the approaches so far are on individual basis. We need a multifaceted joined up strategies to tackle obesity. We need child obesity prevention strategies for families, early child care, and schools receive special focus. Similarly strategies for work place and the health care system, as well as community and national-level strategies for improving the food and built environment. (MH)	Thank you for your comment. We agree that these are important issues, but this guideline updates the clinical practice sections of CG 43. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). Overweight and obese adults: lifestyle weight

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						management services. NICE public health guidance. Publication expected May 2014. Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information.
104	SH	Royal College of General Practitioners	4	General	I would like other approaches to be considered so as the US National Heart, Lung, and Blood Institute We Can! which is a national education program designed for parents and caregivers to help children 8 to 13 years old maintain a healthy weight. (MH)	Thank you for your comment. We agree that these are important issues, but this guideline updates the clinical practice sections of CG 43. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information.
105	SH	Royal College of General Practitioners	5	General	I would like consideration of sugary drinks being barred from being sold in government buildings or schools and to carry a health warning. (MH)	Thank you for your comment. We agree that these are important issues, but this guideline updates the clinical practice sections of CG 43. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public

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						health guidance. Publication expected March 2015. Please refer to the NICE website for more information.
106	SH	Royal College of General Practitioners	6	1 Guideline title	As the evidence base for prevention and for treatment, recommended approaches and definitions of child obesity all differ from in adults, I suggest this document scope is narrowed to apply to adults only and that separate guidance is developed for children and young people. In addition, adult services are commissioned separately from child services, with different goal setting criteria etc and so separate guidance would be more practical. (RP)	We agree that different approaches are required for children. Where relevant, CG43 outlines different recommendations for adults and children. The scope for this work will continue to include adults and children in line with the approach taken by CG43. This update of CG 43 is addressing a limited number of topics from the original guidance, some of which may have relevance to young people. The guideline will review the evidence within these topics for children and young people.
107	SH	Royal College of General Practitioners	7	3.1 a.	There is no comment that child obesity should be plotted on an age-and sex-appropriate growth chart and that adult reference ranges should not be used. (RP)	Thank you for your comment. The advice you allude to is given in section 1.2.2 of CG 43. The current document is a scope rather than guidance. To aid clarity, we have added a footnote to text in section 3.1d which outlines the definitions of child overweight and obesity and related indicators for action.
108	SH	Royal College of General Practitioners	8	3.1 b.c.d. e	No mention of child stats. (RP)	Thank you for your comment. The numbers of children identified as being overweight or obese in 2011 are outlined in section 3.1d
109	SH	Royal College of General Practitioners	9	3.2 c.	VLCD – a significant issue in primary care is the lack of advice about what actually needs monitoring, what aspect raises a safety concern and where a health professional would find this information. Clarifying this would be useful. (RP)	Thank you for your comment. The proposed outcomes include adverse events linked with the interventions covered as part of this update. The GDG may choose to provide information for the NHS based on the reporting of these that may provide advice in this area.
110	SH	Royal College of General Practitioners	10	3.2 f	This would be a really good opportunity to state that follow up needs to be life-long. Small audits in primary care (poster presentations RCGP conference) have shown high incidence of patients lost to bariatric follow up and with nutritional deficiency. Who is responsible for the long term follow up of patients that had a private procedure that only offered a one or two year follow up package? What needs monitoring, how often and what nutritional supplements are	Thank you for your comment. We hope that the evidence reviewed as part of the clinical and cost-effectiveness of follow-up care may give the GDG insight in to some of the issues you raise. The GDG will draft recommendations based on their consideration of the clinical and cost-effectiveness evidence and their clinical experience in this area. The scope for the guideline outlines the setting as all settings in which NHS care is provided. We will be unable to comment on the provision of follow up care packages provided by

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					required? How does this vary according to which procedure was undertaken? Does nutritional supplement requirement correlate in any way with degree of weight reduction? It is not enough to set standards for people undergoing surgery in future – there is already a cohort of patients that have fallen through the follow up net and are at risk of deficiency problems. (RP)	private providers.
111	SH	Royal College of General Practitioners	11	4.1.1. a	Same point – this guidance would be better focusing on adults, with separate guidance for children. (RP)	Thank you for your comment. Where relevant, CG43 outlines different recommendations for adults and children. This update of CG 43 is addressing a limited number of topics from the original guidance, some of which may have relevance to young people. The guideline will review the evidence within these topics for children and young people. The scope for this work will continue to include adults and children in line with the approach taken by CG43.
112	SH	Royal College of General Practitioners	12	4.3.c	There is pressing need for clearer guidance on what to offer patients that have failed with tier 2 community/commercial WM support, but who do not fit criteria for bariatric surgery. Commissioned services at present do not address this group, who may have complex psychological issues or underlying eating disorder, complex co-morbidities and health risks, and thus need MDT input, but without requiring surgical assessment. (RP)	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. The issues which you mention are beyond the remit of this guideline. Please refer to the relevant NICE guidelines such as Eating Disorders http://publications.nice.org.uk/eating-disorders-cg9
113	SH	Royal College of General Practitioners	13	4.4 a	Change in weight and BMI takes far too narrow a focus on numerical change that is not reflective of the wider health gains from lifestyle improvement. Whilst it may be difficult to find a validated measure of other lifestyle gains, improvements in dietary quality and fitness should be heralded as important, because they have an impact on the motivational status of the individual. I think it is very important to seek evidence of broader	Thank you for your comment. The outcomes listed are examples suggested for questions we expect to answer. The list is not exhaustive and will be tailored to the each evidence review. The GDG will take this information into account when prioritising specific outcomes for the included review questions.

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					measures of success and impact from lifestyle improvement and NICE should be flagging up this need. (RP)	
114	SH	Royal College of General Practitioners	14	4.5	I would welcome assessment of self tracking of weight and exercise and strategies to reduce screen time. (MH)	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. We are not updating the lifestyle interventions. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: • Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). • Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. • Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information
115	SH	Royal College of General Practitioners	15	4.5.1 a	Also please clarify what guidance is required for safe monitoring and who should do the monitoring? (GPs are currently often asked to sign VLCD forms, but have little idea why they are asked to sign or what relevance/responsibility it carries) (RP)	Thank you for your comment. Part of the review of the clinical and cost-effectiveness of VLCDs will examine adverse events. The GDG will draft recommendations in this area based on a review of the evidence informed by their clinical experience
116	SH	Royal College of General Practitioners	16	4.5.3 c	I hope this guidance will clarify that long term follow up defaults to NHS responsibility even if the procedure was initially done privately. (RP)	Thank you for your comment.
100	SH	Royal College of Nursing	1	General	There are no comments to submit on behalf of the Royal College of Nursing to inform on the above	Thank you for your comment.

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					scoping consultation at this present time. Thank you for the opportunity to participate.	
121	SH	Royal College of Paediatrics and Child Health	1	1.1.2.3	Original guidance cg43 updating sections 1.1.2.3 through to 5 ought to be within scope. Will it be included in PH guidance scope?	Thank you for your comment. This guideline will update some of the clinical practice sections of CG 43. The NICE Centre for Public Health is undertaking several guidelines which update the public health sections of CG 43 and address public health issues. These include: Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information.
122	SH	Royal College of Paediatrics and Child Health	2	General	We are otherwise happy with the scope.	Thank you for your comment.
19	SH	Royal College of Pathologists	1	4.3 & 4.5	The assessment of the clinical efficacy, adherence to and sustainability of very-low-calorie diets is indeed of importance as their use and evidence base has expanded since the publication of the original NICE Obesity guidance in 2006.	Thank you. We are pleased that you agree that VLCDs is a key issue that should be covered in this guideline update.
20	SH	Royal College of Pathologists	2	4.3 & 4.5	The clinical and commercial use of meal replacement products (which are usually high in protein) and of diets high in protein ± low glycaemic index for weight loss or weight maintenance has also increased significantly	Thank you for your comment. We will be examining the evidence for the use of very low calorie diets defined by CG43 as less than 1000kcal or less per day. Any diet within this category will be included.

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					since 2006. The evidence base has also expanded, e.g. from the Diogenes consortium [1]. Such interventions appear to be efficacious predominantly for weight loss maintenance and may benefit obese patients treated in the NHS. One would therefore recommend that the guidance scope incorporates this area.	
21	SH	Royal College of Pathologists	3	4.3 & 4.5	The evidence base regarding the consumption of a Mediterranean diet has also increased following publication of the PREDIMED trial [2]. In this trial, that recruited participants at high risk of cardiovascular disease predominantly from the overweight and obese range, the consumption of an energy unrestricted Mediterranean diet significantly reduced the incidence of major cardiovascular events compared to a diet low in fat. This finding may benefit obese patients treated in the NHS and one would therefore recommend that the guidance scope incorporates this area.	Thank you for your comment. While this evidence is very interesting, the outcomes of the trial were directed at the reduction in cardio-vascular risk rather than weight reduction.
22	SH	Royal College of Pathologists	4	4.3 & 4.5	The evidence base regarding lifestyle interventions for overweight and obese patients with type 2 diabetes has also increased following a series of publications from the LOOK AHEAD trial e.g. [3]. Even though an intensive weight loss intervention did not significantly reduce the rates of cardiovascular events, it led to improvements of numerous health-related outcomes. This intervention may benefit obese patients treated in the NHS and I would therefore recommend that	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. A review of the lifestyle intervention for overweight and obese patients with Type 2 diabetes has not been prioritised in this update. The NICE Centre for Public Health is undertaking several guidelines which update the public health

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					the guidance scope incorporates this area.	sections of CG 43 and address public health issues. These include: • Managing overweight and obesity among children and young people. NICE public health guidance 47 (2013). • Overweight and obese adults: lifestyle weight management services. NICE public health guidance. Publication expected May 2014. • Maintaining a healthy weight and preventing excess weight gain among children and adults. NICE public health guidance. Publication expected March 2015. Please refer to the NICE website for more information
23	SH	Royal College of Pathologists	5	4.3 & 4.5	The assessment of the clinical efficacy and cost effectiveness of a follow-up care package after bariatric surgery is of very high clinical importance, following the recognition of significant gaps in the care of obese patients. However, there is an urgent clinical need for NICE guidance on a number of other areas that should be incorporated in the guidance scope.	The topics proposed for update listed in CG43 Obesity: review decision December 2011 were reviewed by the Technical Team and discussed with NICE and experts in the field. The topics listed in the scope were selected as those where there was new evidence which would change or clarify the recommendations in CG 43. In addition, a review of the relationship of weight loss, in particular bariatric surgery to type 2 diabetes has been added to the guideline.
24	SH	Royal College of Pathologists	6	4.3 & 4.5	Indications for bariatric surgery: Even though BMONE criteria are currently used as the main indication for bariatric surgery, the results of a number of RCTs (e.g. [4]) and the largest and longest prospective study (Swedish Obese Subject study [5, 6]) suggest that BMONE may be a poor predictor of favourable outcomes (i.e. cardiovascular events, glycaemic improvement) following bariatric surgery. Additionally, the current BMONE cut-off criteria disadvantage patients from ethnic minorities (e.g. South Asians)	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. We will additionally be reviewing the evidence around the clinical and cost-effectiveness of bariatric surgery for the management of recent onset type 2 diabetes in obese people. As part of this review we will consider the needs and differing criteria for ethnic minorities.

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					who may have significant comorbidities at a lower BMONE (i.e. 30-35 Kg/m2). Instead other markers may have a better predictive value (e.g. fasting insulin levels [5]). These findings have important clinical and cost implications for the NHS and should therefore be included in the scope of the updated guidance.	
25	SH	Royal College of Pathologists	7	4.3 & 4.5	Pre-operative "care package": There is a need for the assessment of care packages not only after, but also before bariatric surgery. In fact the latter may be of greater impact as the thorough and multidisciplinary assessment and optimization of patients before surgery may reduce the burden on post-operative care. More specifically, there are a number of complex patient groups that are increasingly being referred to bariatric services and would probably benefit from pre-operative and post-operative interventions/planning. These include patients with: type 1 diabetes, poorly controlled type 2 diabetes mellitus, diabetes related microvascular complications, chronic kidney disease and serious mental health disease. Even though there is lack of RCT evidence on who should manage these patients and how, one would expect that a model based on the cancer or pituitary tumour multidisciplinary team (including a physician, surgeon, specialist nurse, dietician, psychologist/psychiatrist, exercise/sports medicine specialist, all of which should have	Thank you for your comments. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will address post-surgery follow-up. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and does not merit a review at this time. The Guideline Development Group will prioritise sub-groups and interventions for each evidence review. We will raise the issues you raise with them, however, CG43 already details the role of the multidisciplinary team and the competences that should be available (recommendation 1.2.6.9).

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					expertise and experience in bariatric care) would improve clinical care, safety and potentially cost-effectiveness of NHS interventions.	
26	SH	Royal College of Pathologists	8	4.3 & 4.5	Follow-up "care package": In terms of the role of follow-up care packages, the scope/guidance incorporates specific areas should include : a. Use of medications and other therapies after surgery and in particular glucose lowering, blood pressure lowering, lipid lowering and psychiatric medications, and non-invasive ventilation. This is of clinical importance as a significant proportion of comorbidities (type 2 diabetes, sleep apnoea, depression, e.g. [7]) are either not in complete remission or relapse after surgery and many patients are left untreated for long periods of time, therefore potentially increasing the risk of complications and costs to the NHS. b. Appropriate assessment of glycaemic control or remission using well defined and comprehensive criteria (e.g. [8, 9]). c. Definition of poor weight loss/weight regain, assessment and management [10]. This is a relatively new but	Thank you for your comment. The guideline development group will take the issues you raise into consideration when formulating the protocol for this review question. NICE guidance cannot ever address all issues for a specific clinical condition and the GDG will prioritise the outcomes of importance and the subgroups to be considered when developing the protocol for this question. However, please note that pregnant women have been excluded from CG43 and from this scope. NICE has published public health guidance on 'Dietary interventions and physical activity interventions for weight management before, during and after pregnancy'. While this does not address clinical management there is little evidence in this area and the above addresses weight management in pregnancy.

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					significant clinical challenge. d. Assessment and management of addictive behaviours e.g. alcohol, recreational drugs, opioid abuse. These have recently been shown to increase in incidence after bariatric surgery e.g. [11]. e. Pregnancy: Timing and management	
27	SH	Royal College of Pathologists	9	4.3 & 4.5	Adolescents: The evidence base for the use of bariatric surgery in adolescents has increased since 2006 (e.g. [12]). There is a need for clear guidance on the provision of surgery and peri-operative multidisciplinary management of this patient group.	Thank you for your comment. For each topic addressed, the evidence for effectiveness in children and young people will be addressed and where appropriate specific recommendations may be drafted.
28	SH	Royal College of Pathologists	10	4.3 & 4.5	An increasing number of obese patients are denied specific NHS treatments purely due to their BMONE (e.g. in vitro fertilisation, listing for renal transplantation, cardiac and orthopaedic surgery). Even though there is evidence that such treatments are more effective in the normal BMONE range, obese patients also stand to benefit from them. In addition, realistic weight loss goals should be used for patients that are in need of such treatments depending on the patient's BMI. For example having a rigid BMONE cut off of 30 kg/m2 to be listed for renal transplantation in some centres is unrealistic for a patient with a BMONE of 60 kg/m2 considering that the	Thank you for your comment. We assume you are referring to BMI measurement. Whilst you raise some important issues, the specific management of overweight issues and consequent access to the treatments you mention are beyond the remit of this guidance.

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					maximum total body weight loss after bariatric surgery is 40%. One would therefore suggest that this area should be included in the NICE scope/guidance.	
29	SH	Royal College of Pathologists	11	4.3 & 4.5	There is a large gap between the efficacy of lifestyle / pharmacological interventions and bariatric surgery. In addition, many obese patients are at high risk for bariatric surgery (or other types of surgery as above), but would still benefit from weight loss. There is no guidance as to how this group should be managed and in particular whether they may benefit from other available interventions. Examples of these include gastric/vagal stimulators, gastric balloons and the duodenal-jejunal bypass liner. These therapies could potentially be used as a "bridge" to bariatric surgery (or other types of surgery) by facilitating weight loss and lowering the peri-operative risk. There is a clinical need for guidance in this area and would therefore suggest that this area should be included in the NICE scope/guidance.	Thank you for your comment. These areas are of interest but have not been prioritised for this update. They may be considered in future updates of this guideline.
97	SH	Royal College of Physicians	1	4.1.1	This should include men.	Thank you for your comment. We have amended this and not included women as a special group. We believe that the inclusion of women as a special group may have been misleading. Men are included in the scope for this update.
98	SH	Royal College of Physicians	2	4.3H	This should include up to date evidence for surgical interventions.	Thank you for your comment. We have not prioritised a comparative review of the techniques and methods of bariatric surgery at this time. We are aware of the National Institute for Health Research funded By-Band study currently in progress. A comparative review of all

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						interventions may be beneficial after this study reports
99	SH	Royal College of Physicians	3	4.4	This should include complications as well.	Thank you for your comment. The outcomes listed are examples suggested for questions we expect to answer. The list is not exhaustive and will be tailored to the each evidence review. The GDG will take this information into account when prioritising specific outcomes for the included review questions. We anticipate that the inclusion of adverse events as an outcome would capture surgical complications.
117	SH	Royal College of Psychiatrists	1	Page 6	Whilst it is accepted that the obesity guideline will not cover the treatment of eating disorders, including binge eating disorder, it is important that the guideline emphasises the need to establish whether patients presenting with overweight or obesity are suffering from binge eating disorder. This is because such patients will require different management, and if the binge eating disorder is missed then some of the strategies used for the management of weight problems are more likely to be ineffective, or may make the binge eating worse.	Thank you for your comment. CG43 made reference to the NICE guidance on eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders which may provide further information (CG9) when considering this issue. A review of the evidence in this area has not been prioritized for this update.
118	SH	Royal College of Psychiatrists	2	General Comments	Special Groups – people receiving antipsychotic medication.	Thank you for your comment. The Guideline Development group will prioritise the groups of people at special risk of becoming overweight or obese and any available evidence for these groups within the topic area will be reviewed.
119	SH	Royal Pharmaceutical Society	1	General	The Royal Pharmaceutical Society welcomes evidence-based clinical guidance on the prevention, identification, assessment and management of overweight and obesity in children, young people and adults, and agrees with the areas that NICE propose to update and the new areas it will cover. Pharmacists have a significant role in raising	Thank you for your comment the content of which is noted.

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					awareness of the health risks associated with being overweight, providing advice on healthy lifestyles and also supplying medicines and nutritional products to help patients manage their weight. The accessible and inviting environment of pharmacies in the community, allow people to seek advice and have conversations about weight management at a time that is convenient for them, without having to make an appointment.	
120	SH	Royal Pharmaceutical Society	2	4.3	We have noted that NICE does not plan to update CG43 section 1.2.5 Pharmacological Interventions, and that the changes made to the guidance regarding sibutramine in 2010 (following the suspension of its marketing authorisation) are currently communicated in the form of notes within the original guidance. Would this be a good opportunity to reconcile this section of the guidance?	Thank you for pointing this out. When the guideline is published, it will be edited to make clear what sections have been updated and what has been withdrawn.
82	SH	Slimming World	1	General	We welcome the review of these aspects of the guidance and in particular are pleased to see post weight-loss surgery support being looked at as this is an area where there appears to be great disparity across the country with some patients being left feeling very unsupported with negative consequences. We are seeing many people who have been left seeking out additional lifestyle services to support their on-going weight management when follow up care packages after bariatric surgery is found to be lacking.	Thank you very much for your comment the content of which is noted.
83	SH	Slimming World	2	4.5	We would suggest an additional question is added to the review looking at follow up care packages after bariatric surgery. We suggest that the appropriate and necessary level and content of	Thank you for your comment. We are pleased that you agree that follow up care packages after bariatric surgery is an important question.

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					support is looked at and that the guidance document is updated to reflect this (so that it can clearly set out best practice standards). Currently the guidance suggests for example that after the operation regular specialist dietetic support is provided. More guidance on what 'regular' means and for how long would be beneficial and also more guidance on what has been shown to be effective for patients in terms of outcomes, not only weight loss but also the wider determinants of health and wellbeing.	We will take the issues you raise to the guideline development group for consideration when formulating the review question's protocol.
1	SH	Welsh Endocrine and Diabetes Society	1	General	Scope is supported. Pleasing to see that the role of bariatric surgery in newly diagnosed type 2 diabetes is being considered.	Thank you for your comment.

LATE COMMENTS

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1	SH	Imperial Weight Centre, Imperial Healthcare NHS Trust	1	General	The issue of psychological assessment and preparation of patients undergoing bariatric surgery is not adequately addressed, and guidelines to aid clinicians working in this area, which currently suffers from disparate practices, should be set out. Most services recognize the need for psychological services but at which stage and by whom these services are provided is not clear, and the lack of guidelines, even if preliminary, hampers funding of these.	Thank you for your comment. This guideline is an update of CG 43 which will be limited to the topics where new evidence may change recommendations. The guideline update will not address pre-operative assessment as overall the evidence in this area remains equivocal and

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						does not merit a review at this time.
2	SH	Imperial Weight Centre, Imperial Healthcare NHS Trust	2	General	The issue of non-surgical weight loss interventions would be helped by clear guidelines on how these should be set out and implemented within a comprehensive obesity service which offers bariatric surgery. I.e. clarification of the role of dieticians, psychologist/psychiatrists and criteria for going on to receive bariatric surgery after a non-surgical intervention, whether it has failed and even if it has not, given that long term surgical interventions results remain superior to non-surgical.	Thank you for your comment. The GDG may choose to make recommendations around roles of professional interventions based on their review of the clinical and cost-effectiveness of very low calorie diets where it is available. The criteria for referral for bariatric surgery following non-surgical intervention have not been prioritised for inclusion in this update. The issues related to defining the nature of a comprehensive obesity service are outside the scope of this guideline.
8	SH	National Obesity Forum	1	General	The National Obesity Forum (NOF) welcomes NICE's decision to undertake a partial review of Clinical Guidance 43 (CG43), focussing on the sections dealing with very low calorie diets (VLCDs), follow-up care packages after bariatric surgery and the role of bariatric surgery in the management of type 2 diabetes of recent onset in people with obesity.	Thank you for your comments.
9	SH	National Obesity Forum	2	3.2 (b)	We welcome the reference to the 2013 report by the Royal College of Physicians and its conclusions. We would also like to highlight that one of the recommendations of that report was that "evidence-based targets for successful obesity management should be included in the QOF," something which the NOF very much advocates for.	Thank you for your comments.
10	SH	National Obesity Forum	3	3.2(c)	The NOF agrees that the evidence base for VLCDs has expanded since the publication of the NICE guideline on obesity in 2006, and concurs that it is very important to tackle concerns regarding safety, adherence and sustainability of weight loss.	Thank you for your comments.
11	SH	National Obesity Forum	4	3.2 (d)	The NOF would like to highlight that, while the Commissioning Board's guidance published in April 2013	Thank you for your comments.

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					has been a welcomed step, there are still significant issues which affect the adequate commissioning of bariatric surgery. We believe that the publication of guidance on VLCDs will be a step in the right direction to fill the hole which is currently represented by the inadequate provision of tier-3 obesity services, with many patients currently eligible for bariatric surgery but unable to access it.	
12	SH	National Obesity Forum	5	4.1.1 (b)	We believe it is important for NICE to consider the specific requirements of special groups who have a high rate of morbidity, and we hope that suitable interventions will be designed whenever there is sufficient evidence in their favour.	Thank you for your comment. The GDG will prioritise any groups they consider appropriate for special consideration and any available evidence for these groups within the topic area will be reviewed and where appropriate separate recommendations drafted.
13	SH	National Obesity Forum	6	4.3 (c)	The NOF welcomes the inclusion of the role of bariatric surgery in the management of type 2 diabetes of recent onset in people with obesity in the update, as we consider bariatric surgery one of the most effective interventions available for morbidly obese patients with diabetes.	Thank you for your comments.
14	SH	National Obesity Forum	7	4.5	The National Obesity Forum broadly agrees with the review questions set out in the draft scope. In particular, we would like to stress the importance of undertaking a systematic review of the clinical and cost effectiveness of VLCDs in reducing and maintaining weight loss, something which will potentially result in a more systematic adoption of effective programmes across the pathway	Thank you for your comments.
15	SH	National Obesity Forum	8	4.6	We welcome the review of the economic aspects of alternative interventions. As highlighted above, we believe that this is a crucial step to enable healthcare professionals to correctly identify the most effective solutions within the spectrum of therapeutic options available.	Thank you for your comments.
3	SH	NHS ENGLAND	1	4.3 c 4.5.2 b	There is new data on the relapse rate of diabetes following bariatric surgery so I think it would be useful to consider the	Thank you for your comment. This guideline will concentrate on obese

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				4.6	cost effectiveness of bariatric surgery in patients who have not developed diabetes compared with those who have established diabetes.	patients with type 2 diabetes. Evidence is available which suggests that bariatric surgery is cost effective for obese patients without type 2 diabetes. Our findings can be compared alongside these. However it is worth noting that the decision to recommend bariatric surgery for those without type 2 diabetes will not be contingent on whether or not surgery is cost effective for those with type 2 diabetes.
4	SH	NHS ENGLAND	2	4.1.1 b	There are some time limited disorders that might be considered by some to indicate an urgency for bariatric surgery. At present CG43 only includes patients with BMI>50 but how about patients awaiting transplants, cancer therapy or infertility.	Thank you for your comment. A review of the evidence behind the thresholds for referral for bariatric surgery has not been prioritised for update on this occasion.
5	SH	NHS ENGLAND	3		Many patients have revisional surgery ie second and third operations for failure to lose weight. Is this appropriate and what should the indications be?	Thank you for your comment. A review of the evidence behind the frequency of revisional bariatric surgery has not been prioritised for update on this occasion.
6	SH	NHS ENGLAND	4	4.3 b 4.5.3 c	Agree that follow up packages are important. Currently commissioning is only for 2 years. Please consider whther this is sufficiently long, what should be done as good practice for follow up and who should take responsibility for ensuring that it is done.	Thank you for your comment. We will share the points you make with the GDG who will finalise the content of the review question in this area.
7	SH	NHS ENGLAND	5	4.3. b	Follow up will be a particular problem for adolescents – please consider how this can be optimised	Thank you for your comment. We will share the point you make with the GDG who will finalise the content of the review question in this area.

These organisations were approached but did not respond:

4 Children

AbbVie

abolished - Health Promotion Agency for Northern Ireland

Action for Sick Children

Action on Pre-Eclampsia

Advertising Association

Aintree University Hospital NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust

All Wales Dietetic Advisory Committee

All Wales Senior Nurses Advisory Group

Allergan Ltd UK

Allocate Software PLC

Amgen UK

AMORE health Ltd

AMORE Studies Group

Anglian Community Enterprise

Apetito Ltd

Arthritis and Musculoskeletal Alliance

Arthritis Care

Assocation of NHS Occupational Physicians

Association for Continence Advice

Association for Family Therapy and Systemic Practice in the UK

Association for Respiratory Technology and Physiology

Association for the advancement of meridian energy techniques

Association of Anaesthetists of Great Britain and Ireland

Association of Breastfeeding Mothers

Association of British Healthcare Industries

Association of British Insurers

Association of Children's Diabetes Clinicians

Association of Clinical Pathologists

Association of Directors of Adult Social Services

Association of Directors of Childrens Services

Association of Surgeons of Great Britain and Ireland

Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland

Astrazeneca UK Ltd

Atkins Nutritional Inc

Audit Commission

B. Braun Medical Ltd

Barnet Primary Care Trust

Barnsley Hospital NHS Foundation Trust

Barnsley Primary Care Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust

Bath Spa University

Big Lottery Fund

Birmingham City Council

Black and Ethnic Minority Diabetes Association

Black Country Cancer and Cardiac Network

blackpool teaching hospitals nhs trust

Blood Pressure UK

Boehringer Ingelheim

Bolton Council

Boots

Bradford District Care Trust

Bristol University

Bristol-Myers Squibb Pharmaceuticals Ltd

British Acupuncture Council

British Association for Counselling and Psychotherapy

British Association for Nursing in Cardiovascular Care

British Association for Parenteral & Enteral Nutrition

British Association of Behavioural and Cognitive Psychotherapies

British Association of Dramatherapists

British Association of Plastic Reconstructive and Aesthetic Surgeons

British Association of Psychodrama and Sociodrama

British Association of Sport and Exercise Medicine

British Cardiovascular Society

British Dental Trade Association

British Dietetic Association

British Geriatrics Society - Gastro-enterology and Nutrition Special Interest Group

British Geriatrics Society

British Healthcare Trades Association

British Heart Foundation

British Heart Foundation National Centre for Physical Activity & Health

British Hypertension Society

British Liver Trust

British Lymphology Society

British Medical Association

British Medical Journal

British National Formulary

British Nuclear Cardiology Society

British Nutrition Foundation

British Obesity Surgery Patients Association

British Obesity Surgery Society

British Orthopaedic Association - Patient Liaison group

British Psychological Society

British Psychological Society

British Red Cross

British Society for Paediatric Endocrinology and Diabetes

British Society of Gastroenterology

British Society of Paediatric Gastroenterology Hepatology and Nutrition

British Specialist Nutrition Association

British Thoracic Society

BSPGHAN

Buckinghamshire Primary Care Trust

Calderstones Partnerships NHS Foundation Trust

Cambridge Neurotechnology

Cambridge University Hospitals NHS Foundation Trust

Camden Link

Cancer Research UK

Capsulation PPS

Capsulation PPS

Cardiff and Vale NHS Trust

Care Quality Commission (CQC)

Cegedimrx

Central & North West London NHS Foundation Trust

Central Lancashire Primary Care Trust

Central London Community Health Care NHS Trust

Central London Community Health Care NHS Trust

Centre for Health Services Studies

Centrepoint

Chartered Physiotherapists in Mental Health

Chartered Physiotherapists Promoting Continence

Chartered Society of Physiotherapy

Chesterfield Primary Care Trust

Child Growth Foundation

Children, Young People and Families NHS Network

Christian Medical Fellowship

Church Grange Surgery

CIS' ters

City and Hackney Teaching Primary Care Trust

City Hospitals Sunderland NHS Foundation Trust

Clarity Informatics Ltd

Cochrane Developmental, Psychosocial and Learning Problems

Colchester Hospital University NHS Foundation Trust

Community Practitioners' & Health Visitors Association

Co-operative Pharmacy Association

Counselling and Psychotherapy Trust

Counterweight Programme, The

Countess of Chester Hospital NHS Foundation Trust

Covidien Ltd.

Croydon Clinical Commissioning Group

Croydon Health Services NHS Trust

Croydon Primary Care Trust

Croydon University Hospital

Cumbria Partnership NHS Trust

Cwm Taf Health Board

Cyberonics

David Lewis Centre, The

Deltex Medical

Department of Academic Psychiatry - Guy's

Department of Health, Social Services and Public Safety - Northern Ireland

Derbyshire County Council

Device Access UK Ltd

Devon Partnership NHS Trust

Diabetes & Wellbeing Ltd

Diabetes Management and Education Group

Diabetes UK

Diennet Ltd

Diet Plate Ltd, The

Dieticians in obesity management

DO NOT USE

Doncaster Primary Care Trust

Dorset Primary Care Trust

Ealing Public Health

East and North Hertfordshire NHS Trust

East Kent Hospitals University NHS Foundation Trust

Eastbourne District General Hospital

Eating Disorder Association (NI)

Economic and Social Research Council

Education for Health

Eisai Ltd

Eli Lilly and Company

Equalities National Council

Ethical Medicines Industry Group

Expert Patients Programme CIC

Experts in Severe and Complex Obesity

Faculty of Dental Surgery

Faculty of Public Health

Faculty of Sport and Exercise Medicine

Fair Play for Children

Fatherhood Institute

Federation of Bakers

Fibroid Network Charity

Fitness Industry Association

Five Boroughs Partnership NHS Trust

Food Advertising Unit

Food Standards Agency

Foundation for Liver Research

Foundation Trust Network

Gelita UK Limited

General Hypnotherapy Register

GeneWatch UK

George Eliot Hospital NHS Trust

GlaxoSmithKline

Gloucestershire County Council

Gloucestershire LINk

Gravitas

Great Western Hospitals NHS Foundation Trust

Greater Manchester West Mental Health NHS Foundation Trust

Green Machine, The

Guy's and St Thomas' NHS Foundation Trust

H & R Healthcare Limited

Hammersmith and Fulham Primary Care Trust

Hampshire Partnership NHS Trust

Havencare

Hayward Medical Communications

Health & Social Care Information Centre

Health and Care Professions Council

Health Quality Improvement Partnership

Healthcare Improvement Scotland

Healthcare Infection Society

Healthier Weight Centre, The

Healthwatch East Sussex

Heart of Mersey

HEART UK

Hertfordshire Partnership NHS Foundation Trust

Hertfordshire Partnership NHS Trust

Herts Valleys Clinical Commissioning Group

Hindu Council UK

Hockley Medical Practice

Homerton Hospital NHS Foundation Trust

Humber NHS Foundation Trust

IGD

Independent Healthcare Advisory Services

Institute of Sport and Recreation Management

Integrity Care Services Ltd.

International Neuromodulation Society

International Obesity Task Force of the International Association for the Study of Obesity

International Size Acceptance Association

iQudos

Janssen

Jenny Craig

JKP Analysts, LLC

Johnson & Johnson

Johnson & Johnson Medical Ltd

KasTech Ltd

KCI Medical Ltd

Ki Performance

Kidney Cancer Support Network

King's College Hospital NHS Foundation Trust

Kingston Primary Care Trust

Knowsley Primary Care Trust

Lancashire Care NHS Foundation Trust

Lanes Health

Laurence-Moon-Bardet-Biedl Society

Leeds Community Healthcare NHS Trust

Leeds Metropolitan University

Leeds North Clinical Commisioning Group

Leeds Teaching Hospitals NHS Trust

Leg Ulcer Forum

Lilly UK

Limbless Association

Lincolnshire County Council

Liverpool John Moores University

Liverpool Primary Care Trust

Liverpool Women's NHS Foundation Trust

Living Streets

Local Government Association

Local Government Information Unit

Luton and Dunstable Hospital NHS Trust

Maidstone Hospital

Maquet UK Ltd

McNeil Nutritionals Ltd

Meat & Livestock Commission

Medical Support Systems Limited

Medicines and Healthcare products Regulatory Agency

MEND

Mental Health Group - British Dietetic Association

Mid Staffordshire NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust

Midwives Information and Resource Service

Mind Wise New Vision

Mindfulness Centre of Excellence

Ministry of Defence (MOD)

Morecambe Bay Public Health Development

MRC Centre of Epidemiology for Child Health

MRC Human Nutrition Research

Msb consultancy

National Association of British and Irish Millers

National Association of Primary Care

National Centre for Eating Disorders

National Children's Bureau

National Clinical Guideline Centre

National Collaborating Centre for Cancer

National Collaborating Centre for Mental Health

National Collaborating Centre for Women's and Children's Health

National Deaf Children's Society

National Institute for Health Research Health Technology Assessment Programme

National Institute for Health Research

National Institute for Mental Health in England

National Nurse Consultants in CAMHS forum

National Obesity Forum

National Patient Safety Agency

National Youth Advocacy Service

Natural England

NDR UK

Nestle UK Ltd

Newcastle University

Newcastle upon Tyne Hospitals NHS Foundation Trust

NHS Barking & Dagenham CCG

NHS Barnsley Clinical Commissioning Group

NHS Camden

NHS Confederation

NHS Connecting for Health

NHS Cornwall and Isles Of Scilly

NHS County Durham and Darlington

NHS Derbyshire county

NHS Direct

NHS England

NHS Gloucestershire

NHS Greater Manchester Commissioning Support Unit

NHS Halton CCG

NHS Hampshire

NHS Health at Work

NHS Improvement

NHS Islington

NHS Milton Keynes

NHS Newcastle

NHS Norfolk Primary Care Trust

NHS North West

NHS Nottingham City

NHS Plus

NHS Sheffield CCG

NHS South Cheshire CCG

NHS Southern Derbyshire CCG

NHS Sussex

NHS Sutton and Merton

NHS Wakefield CCG

NHS Wandsworth

NHS Warwickshire North CCG

NHS Warwickshire Primary Care Trust

NHS Yorkshire and the Humber Strategic Health Authority

Nightingale Care Beds Ltd

NLSSM The School of Sports Massage

Nordic Surgical Ltd.

Norfolk Suffolk & Cambridgeshire Strategic Health Authority

Norgine Limited

North and East London Commissioning Support Unit

NORTH EAST LONDON FOUNDATION TRUST

North of England Commissioning Support

North Staffs PCT

North Tees and Hartlepool NHS Foundation Trust

North West London Hospitals NHS Trust

North West London Perinatal Network

North Yorkshire & York Primary Care Trust

Northamptonshire county council

Northern Ireland Chest Heart and Stroke

Northumberland, Tyne & Wear NHS Trust

Nottingham City Council

Nottingham City Hospital

Nottingham Healthcare NHS Trust

Nottingham University Hospitals NHS Trust

Nottinghamshire Healthcare NHS Trust

Novo Nordisk Ltd

Nuffield Council on Bioethics

Nutmeg UK Ltd

Nutricia Clinical Care

Nutrition Society

Obesity Management Association

Obstetric Anaesthetists' Association

Optical Confederation, The

Overeaters Anonymous

Oxford Health NHS Foundation Trust

Oxfordshire Clinical Commissioning Group

Oxfordshire Primary Care Trust

Pancreatic Cancer Action

Parenteral and Enteral Nutrition Group

Patient Assembly

Perfect Portion Control Ltd

PERIGON Healthcare Ltd

Peterborough City Hospital

Peterborough Primary Care Trust

Pfizer

Pharmacosmos

Pharmametrics GmbH

PharmaPlus Ltd

PHE Alcohol and Drugs, Health & Wellbeing Directorate

Play England

Plymouth Hospitals NHS Trust

Powys Local Health Board

PrescQIPP NHS Programme

Primary Care Cardiovascular Society

Primary Care Dermatology Society

Primary Care Diabetes Society

Primary Care Partnerships

Primary Care Pharmacists Association

Primary Care Rheumatology Society

Primrose Bank Medical Centre

PROMIS Recovery Centre

Proprietary Association of Great Britain

Psychologists in Obesity Network

Public Health Wales NHS Trust

Queen Elizabeth Hospital King's Lynn NHS Trust

Queen's University Belfast

Randox Laboratories Limited

Rarer Cancers Foundation

Renal Nutrition Group, British Dietetic Association

Residential Community Care Services

RioMed Ltd.

Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust

Roche Products

Rotherham Metropolitan Borough Council

Royal Berkshire NHS Foundation Trust

Royal Brompton Hospital & Harefield NHS Trust

Royal College of Anaesthetists

Royal College of General Practitioners in Wales

Royal College of Midwives

Royal College of Midwives

Royal College of Obstetricians and Gynaecologists

Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition

Royal College of Physicians of Edinburgh

Royal College of Psychiatrists in Wales

Royal College of Radiologists

Royal College of Surgeons of Edinburgh

Royal College of Surgeons of England

Royal Cornwall Hospitals NHS Trust

Royal Free Hospital NHS Foundation Trust

Royal Manchester Children's Hospital

Royal National Institute of Blind People

Royal Society of Medicine

Royal United Hospital Bath NHS Trust

Sands, the stillbirth and neonatal death charity

Sanofi

School Food Trust

Scottish Intercollegiate Guidelines Network

Sheffield Childrens Hospital

Sheffield Hallam University

Sheffield Health and Social Care NHS Foundation Trust

Sheffield Primary Care Trust

Sheffield Teaching Hospitals NHS Foundation Trust

Sin and Slim Diet, The

Slender Thoughts

Slim Fast Foods Limited

SNDRi

Social Care Institute for Excellence

Social Interface

Society for Academic Primary Care

Society for Endocrinology

South Asian Health Foundation

South Gloucestershire Council

South London & Maudsley NHS Trust

South London Cardiac and Stroke Network

South Warwickshire NHS Foundation Trust

South West London Strategic Health Authority

South West Yorkshire Partnership NHS Foundation Trust

Southern Health Foundation Trust

Southport and Ormskirk Hospital NHS Trust

Sport England

St Andrews Healthcare

St Andrew's Hospital

St Georges Healthcare NHS Trust

St Mary's Hospital

Staffordshire and Stoke on Trent Partnership NHS Trust

Stockport Clinical Commissioning Group

Stockport Primary Care Trust

Sure Start Ashfield

Sure Start Tamworth

Sussex Partnership NHS Foundation Trust

Sustrans

Tanita UK Ltd

Tavistock Centre for Couple Relationships

Tees, Esk and Wear Valleys NHS Trust

Telemedcare Ltd

Telford and Wrekin Primary Care Trust

Teva UK

The Association for Clinical Biochemistry & Laboratory Medicine

The Association of the British Pharmaceutical Industry

The British Homeopathic Association & Faculty of Homeopathy 131134

The Fostering Foundation

The Hospital Group

The National LGB&T Partnership

The Patients Association

The Princess Alexandra Hospital NHS Trust

The Rotherham NHS Foundation Trust

The Stroke Association

The Work Foundation

Tissue Viability Society

Tommy's - The Baby Charity

UK Health Forum

UK National Screening Committee

UK Specialised Services Public Health Network

Unite - the Union

United Kingdom Council for Psychotherapy

United Lincolnshire Hospitals NHS

University College London

University College London Hospital NHS Foundation Trust

University Hospital Aintree

University Hospital Birmingham NHS Foundation Trust

University Hospitals Birmingham

University of Leeds

University of Wales, Newport

Vifor Pharma UK Ltd

Walsall Local Involvement Network

Walsall Teaching Primary Care Trust

Warrington Primary Care Trust

Weight Concern

Weight Management Centre

Welsh Government

West Hertfordshire Hospital Trust

West London Mental Health NHS Trust

West Middlesex University Hospital NHS Trust

West Sussex Public Health

Western Cheshire Primary Care Trust

Western Sussex Hospitals NHS Trust

Whitehouse Consultancy

Wigan Leisure and Culture Trust

Wirral University Teaching Hospital NHS Foundation Trust

WLSinfo

Wolverhampton City Primary Care Trust

Worcestershire Acute Hospitals Trust

World Cancer Research Fund

Wound Care Alliance UK

Wye Valley NHS Trust

Wyre Forest Primary Care Trust

York Hospitals NHS Foundation Trust

Young Diabetlolgists Forum