Obesity: identification and classification of overweight and obesity (update)

Consultation on draft guideline - Stakeholder comments table
08/04/22 to 11/05/22

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ABL Health	Guideline	005	005	We like the idea of using waist–to–height measurements but feel this should be driven by a stong comms campaign to empower people to measure themselves as the majority of T2 services is in groups so measuring people is not appropriate.	Thank you for your comment. NICE does not have a remit to undertake national communication campaigns, however we will pass this comment on to our communications team with a view to having the information included in any press releases about this guideline.
ABL Health	Guideline	006	028	We feel that if a person is told about the severity of their obesity and their risks, the discussion must include the support that can be offered I.e., local service provider, NHS programmes, commercial programmes.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language. It should also be noted that further work has been planned for the guideline, which includes a review into increasing uptake of weight management services in adults, children and young people. For further information please refer to the scope.
ABL Health	Guideline	007	012	Offer a higher level of intervention to people with weight-related 13 comorbidities, regardless of their waist-to-height ratio. Adjust the	Thank you for your comment. The committee noted that in practice, people with comorbidities are not offered appropriate treatment early enough. The committee further highlighted that in groups of people

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				14 approach depending on the person's clinical need. See NICE's guideline 15 on obesity: identification, assessment and management: section 1.3 for 16 details of comorbidities; recommendation 1.11.1 for people with a BMI 17 over 35 kg/m² with recent onset of diabetes; and recommendations 1.3.7 18 and 1.10.7 for people with a BMI over 50. [2022, replaces CG189 19 recommendation 1.2.11] Patients with weight-related comorbidities regardless of size may represent higher clinical risk, however, they may only need more basic intervention as their needs depend on a number of factors (level of nutrition education, upbringing, psychosocial factors and other barriers). Conversely, those with few or no weight-related comorbidities but who have disordered eating that requires psychological therapies clearly need the higher level intervention. In our experience, clinical risk did not correlate to needing higher level of intervention. Each case must be considered on merit, and we find that considerations include (but is not exhaustive): - Disordered eating scores (binge/compulsive eating, emotional eating) - Weight loss journey so far - Comorbidities - Level of metabolic risk	such as those newly diagnosed with type 2 diabetes and those with BMI over 50, immediate action needs to be taken. However, recommendation 1.2.16 does state that a person's clinical needs also need to be taken into consideration. The committee also agreed that patient centred care is important and based on the stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight this as well as resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				What has been tried before – have they already been through a weight management service or have they tried for years to lose weight without success?	
British Dietetic Association	Guideline	008	General	Rec 1.2.2 – we feel it is important to clarify that BMI should only be used in children from the age of 2 as BMI changes rapidly in <2 years and weight gain rather than BMI has been shown to be more indicative of future overweight and obesity.	Thank you for your comment. Children aged under 2 years are out of scope of this guideline. Additionally, based on stakeholder feedback, reference to the childhood and puberty close monitoring form has been amended to state that it can be used in children aged 2 and over.
British Dietetic Association	Guideline	008	General	Rec 1.2.3 – while we understand why waist-to-height ratio has been adopted as a measure of central adiposity and metabolic risk factors, we are concerned that healthcare professionals will not be equipped to measure waist circumference accurately and sensitivity in children and young people. This is relatively new measurement in paediatrics therefore training and resource provision is essential. To minimise errors, we suggest that the guideline stipulates that the measurements should be performed and repeated by the same, trained personnel where possible. Furthermore, this measure should not supersede or undermine BMI, and should be considered and interpreted alongside BMI to avoid misinformation, e.g., a child or young person with a normal waist-to-height ratio should not believe their overweight/obesity is not related to risk of complications.	Thank you for your comment. The committee took training needs of healthcare professionals into consideration when drafting recommendations. As highlighted the rationale and impact section of the guideline, the committee were aware that waist to height ratio (WHtR) is not routinely calculated in practice and the introduction of this measure might result in additional training costs. Based on stakeholder feedback, the committee agreed that WHtR should be conducted by trained personnel, though they highlighted that having the measurements repeated by the same personnel may not be feasible in practice. In their clinical experience, growth measurements are not repeated by the same personnel, therefore, this does not need to be a requisite for WHtR measurements. The rationale and impact section has been amended to highlight this. The rationale and impact section has also been amended to state that while training resources aren't

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					available for WHtR, there are resources that can be used to understand how waist should be measured. The committee do not wish for WHtR to supersede BMI, and as highlighted in recommendation 1.2.21, BMI has been endorsed as the main measurement for overweight and obesity.
British Dietetic Association	Guideline	008	017	Rec 1.2.2 – there are limited specialist growth charts available in the UK with BMI conversion charts therefore it would be more accurate to specify 'Refer to Down's syndrome growth charts if needed' instead (as these are the only ones available).	Thank you for your comment. The committee has altered the recommendation 1.2.21 to highlight that special BMI growth charts are available for children and young people with Down's syndrome. Section 1.1.11 in evidence review B has also been amended to capture the committee discussion.
British Dietetic Association	Guideline	009	General	Rec 1.2.6. – we agree that the permission of the child, young person, parent and/or carer should be sought before discussing excess weight, BMI and central adiposity but the guideline should specifically state the importance of using people first language, in a non-stigmatising way.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
British Dietetic Association	Guideline	009	General	Rec 1.2.7 and 1.2.8 – specific recommendation to lifestyle weight management service with multi-component frameworks (on diet, forming healthy habits, emotional wellbeing, physical activity and	Thank you for your comment. Further work has been planned for this guideline to evaluate the effectiveness of weight management programmes in children and young people. For

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				sedentary time) that target behaviour change, which are age-specific, personalised and culturally appropriate aimed at tier 2 and 3 level services should made. Continued… Furthermore, it is important to highlight that many children's weight management services have been decommissioned so the guidelines should encourage that these services are commissioned as a priority. Dietitians are integral and skilled in leading these services therefore we suggest the guidelines highlights recommend referral in the absence of services and/or multidisciplinary teams.	further information, please refer to scope of the guideline. The committee are also aware of the issues around commissioning of services, however commissioning of services is outside the remit of this committee and the work conducted as part of this update.
British Dietetic Association	Guideline	017	016	As mentioned earlier, performing waist circumference accurately in children and young people is challenging, both in terms of accuracy of the measurement itself and sensitively towards the child/young person and parent/carer, so measurements should be performed by the same, trained personnel.	Thank you for your comment. Based on stakeholder feedback, the committee agreed that waist-to-height should be conducted by trained personnel, though they highlighted that having the measurements repeated by the same personnel may not be feasible in practice. In their clinical experience, growth measurements are not repeated by the same personnel, therefore, this does not need to be a requisite for waist-to-height measurements. The rationale and impact section has been amended to highlight this.
British Dietetic Association	Guideline	017	020	As mentioned earlier, the only available specialist growth charts with BMI monitoring available in the UK are for Down's syndrome therefore this paragraph	Thank you for your comment. The committee has altered the recommendation 1.2.21 to highlight that special BMI growth charts are available for children and young people with Down's syndrome.

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				should not assume there are other condition specific growth charts with BMI conversion available.	Section 1.1.11 in evidence review B has also been amended to capture the committee discussion.
British Dietetic Association	Guideline	019	014	Stating that 'sitting height' and 'specialist assessment may be needed' is ambiguous and need more clarification. There are no proxy measurements for height that are validated for children and young people in the UK (e.g., such as knee height, ulna length, etc) which makes assessment of excess weight difficult in those unable to weight-bear or with physical or learning difficulties.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section has been amended to state that validated proxy measures are not available for children and young people. Additionally, further information has been added on the reasonable adjustments that may be required for children and young people using wheelchairs. The committee have also included children and young people with special educational needs and disability, physical disabilities and physical conditions as important subgroups in the research recommendation. Appendix L in evidence review B has also been amended.
British Dietetic Association	Guideline	019	015	The published guidelines on the assessment of people with learning disabilities in obesity and weight management mentioned do not contain appropriate proxy measures for height for children and young people therefore it is inaccurate to state that these guidelines should not represent practice change, as it is ignoring that it is already difficult to measure in this group. As such, understanding better, more sensitive and less invasive measures of excess weight (and height) should be included as an area for further research.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section has been amended to state that validated proxy measures are not available for children and young people. Additionally, further information about the reasonable adjustments that may be required for children and young people using wheelchairs. The committee have also included children and young people with special educational needs and disability, physical disabilities and physical conditions as important subgroups in the research recommendation.

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					Appendix L in evidence review B has also been amended.
British Psychological Society	General	General	General	Reference: "Psychological perspectives on obesity: Addressing policy, practice and research priorities" British Psychological Society, 2019 https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Psychological%20Perspectives%20on%20Obesity%20-%20Addressing%20Policy%2C%20Practice%2C%20and%20Research%20Priorities.pdf	Thank you for your comment. This report offers recommendations linked to psychological evidence and perspectives linked to people living with obesity. It is not primary research or a formal systematic review and as such would not be included in an evidence review. However, it is relevant and mirrors the committee's belief that psychological care assessment and care are vital in weight management. This is also covered in CG189, for example recommendation 1.10.9 states that surgery for obesity should be undertaken only by a multidisciplinary team that can provide psychological support before and after surgery.
British Psychological Society	Guideline	006	025	It is good to see reference to asking for permission prior to talking about weight. BPS recommends that the guidelines also include a recommendation to have the appropriate consultation skills to talk about weight and to use language and imagery that does not stigmatise and lead to disengagement with services (BPS, 2019).	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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British Psychological Society	Guideline	014	021	BPS believes that the notion that "*knowledge of the linked conditions may support adherence to a weight loss strategy"* overlooks the evidence base that knowledge alone will not change behaviour (BPS, 2019). Individuals need a structure support programme, offering emotional and psychological support in addition to knowledge and risk communication.	Thank you for your comment. The committee agreed that support is an integral part of care. As the focus of this update was on identification and classification of overweight, obesity and central adiposity, committee were unable to draft recommendations on support programmes. However, CG189 does include recommendations that specifically focus on the support that should be offered. For example, recommendation 1.4.4 states that as part of lifestyle interventions, support should be offered depending on the person's needs and be responsive to changes over time. Additionally, the scope of this update includes the amalgamation of 8 different guidelines, which means recommendations will be available in one coherent guideline. For further information, please refer to the scope.
British Psychological Society	Question Response	N/A	N/A	In response to question 3-"What would help users overcome any challenges?"- BPS suggests the following (BPS, 2019): • A nationwide training and supervision programme in the provision of psychologically informed behavioural support for weight management should be made available to all those working with people to help them to lose weight and maintain weight loss • All health professionals delivering weight management initiatives should have regular supervision sessions with a practitioner	Thank you for your comment. The committee agreed that services such as training and supervision programme in the provision of psychologically informed behavioural support would be useful. However, currently, provision of such services may not feasible. The committee agreed on the importance of public health campaigns remaining sensitive when discussing weight management however, public health campaigns are outside the remit of NICE.

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				psychologist to increase their awareness of how mental health conditions and psychological factors can contribute to obesity and the success of treatment • Public health campaigns targeting weight management should avoid framing obesity as a simple 'choice' and use psychological evidence and expertise in the campaign design process	
British Society of Lifestyle Medicine	Guideline	005	005	1.1.4 We can tackle the challenge of introducing waist-height ratio by giving an open invite for service users to assess their risk. Interestingly, most individuals already have an idea of some of the risk of central adiposity. However, we just need to assist them in quantifying their individual risk. A national and local campaign will be a good start in getting people familiar with the term. Then having an accessible risk calculator will be ideal.	Thank you for your comment. NICE does not have a remit to undertake national communication campaigns and local campaigns are a matter for local negotiation and commissioning. However, we will pass this comment on to our communications team with a view to having the information included in any press releases about this guideline. The committee were unaware of an NHS waist-to-height ratio calculator but agreed that this would be a useful tool. To further explain waist-to-height ratio, the guideline has been amended to provide details on how the waist should be measured and how waist-to-height should be calculated.
British Society of Lifestyle Medicine	Guideline	006	007	1.1.9 I am concerned that this may imply specific health benefits with increased adiposity in over 65's. Although undernutrition is definitely an issue in this age group, it is important health care professionals can identify those at an increased risk and provide specific nutritional advice. The risk of sarcopenic obesity might	Thank you for your comment. The committee agreed that sarcopenic obesity is an important factor to be taken into consideration and that healthcare professionals should be cautious when interpreting BMI in older people aged 65 and over. It was further noted that while recommendation 1.2.10 does not

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				be over looked if health care professionals start associating adiposity with better nutrition which is not entirely true. The advice for these patients might not necessarily be to lose weight, instead we can encourage them to increase their protein intake and strength-based activity to increase muscle mass.	specifically list sarcopenia or sarcopenic obesity as factors that need to be taken into consideration, the recommendation does include functional capacity, which can be affected if a person has sarcopenic obesity. The rationale and impact section of the guideline has been amended to provide further clarification. Furthermore, the committee agreed that due to the limited evidence identified in older people, further recommendations in this population could not be drafted. Therefore, the committee included older people as an important subgroup in the research recommendation (see appendix L in evidence review A for further information).
British Society of Lifestyle Medicine	Guideline	006	009	1.1.9 Just wondered if there might be any added benefits of reminding service providers and users to have an up-to-date height for over 65's who are likely to experience vertebral compression due to loss of vertebral height.	Thank you for your comment. The committee highlighted that there is disparity in practice when it comes to taking measurements in older people. The committee noted that it is currently unclear whether a person's new height or previous height should be utilised in the calculations. Additionally, they noted that they are not aware of studies which focus on this issue. Section 1.1.11 in evidence review A has been amended to highlight committee discussions. Additionally, limited evidence was identified for older people. Based on this, appendix L has been amended to include older people as a subgroup.

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British Society of Lifestyle Medicine	Guideline	009	014	1.2.6 I do agree that it will be most difficult to implement the use of waist-height ratio for children and adolescents due to the stigma in society lack of parental awareness and lack of confidence amongst service providers.	Thank you for your comment. Committee did knowledge that stigma is an issue when it comes to discussing the degree of overweight and obesity. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
British Society of Paediatric Dentistry	Guideline	4	17	Use of NHS BMI healthy weight calculator recommended for adults - there is no mention of this for children and young people. Is there a reason for this or can the 'child' version of this calculator be recommended for an indication of potential overweight/obesity alongside growth charts which are mentioned in the guidance?	Thank you for your comment. The NHS Healthy weight calculator was referenced in the recommendations as a resource that provides information on how to measure waist when self-measuring. The committee also highlighted that when defining overweight and obesity in children and young people, growth and BMI charts linked in recommendation 1.2.21 are the best available resource.
British Society of Paediatric Dentistry	Guideline	8	4	Given the strong association between obesity and poor oral health, the British Society of Paediatric Dentistry (BSPD) recommends measuring height and weight at routine dental appointments in line with our position statement: https://www.bspd.co.uk/Portals/0/Obesity%20a	Thank you for your comment. The committee are aware that some university aligned dental groups have been involved with taking measurements, however it is unclear if this takes place across all

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				nd%20Dental%20Health%20Final%20PS%20Final%20Dec%202020.pdf	dental practices and is outside the remit of this guidance.
British Society of Paediatric Dentistry	Guideline	8	6	please amend to include oral health and include this reference: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/844121/BMI_dental_caries.pdf#:~:text=Childhood%20excess%20weight%20is%20a%20significant%20population%20health,%282017%293%20showed%20that%20almost%20a%20quarter%20%2823.3%25%29%20of	Thank you for your comment. The committee noted that in some university aligned dental groups have been involved in conducting measurements, however it is unclear if this takes place across all dental practices. This is also outside the remit of this guidance.
British Society of Paediatric Dentistry	Guideline	8	9	Are these the terms preferred by CYP? Has there been engagement work around this? If so, why are we using the term "Excessive weight" in NHSE/I e.g. CEW clinics. Other terms, less likely to induce stigma are being used such as above a healthy height / living with obesity / higher weight.	Thank you for your comment. As part of this update, engagement work was not conducted on preferred terms for CYP. However, it should be noted that clinical definitions of overweight and obesity were used in recommendation 1.2.24 which are also used by the Royal College of Paediatrics and Child health (RCPCH). The committee opted to use clinical definitions instead of population definitions (e.g., overweight and very overweight) as these can be stigmatising. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of

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					overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language..
British Society of Paediatric Dentistry	Guideline	9	14	Has there been any discussion / recommendation on when to discuss overweight/obesity in the presence of the child / young person concerned? The recommendation seems to suggest to always involve the child / young person (by seeking consent to discuss) but an approach within paediatric dentistry (secondary care) has been to use clinical judgement when this would be appropriate. We would often discuss out with hearing of the child/young person and with their parent / carer only, e.g. for young children, to determine family thoughts and wishes to engage with any support and avoid any potential negative impacts on the child.	Thank you for your comment. The committee took your comment into consideration and have amended recommendation 1.2.27 to highlight that degree of overweight, obesity and central adiposity should be discussed in a sensitive and **age-appropriate** manner. Rationale and impact section as well section 1.1.11 in evidence review B have also been amended to reflect this change.
British Society of Paediatric Dentistry	Guideline	9	18	We need to ensure there is adequate provision of dietetic services, if a need is identified by the dental team. There is great regional variation in services available and eligibility referral criteria. It is also noted that in some regions, not all children of all ages / BMI centiles have a child/young person weight service they can be referred to for support.	Thank you for your comment. The focus of this update was on identifying and assessing overweight and obesity in adults, children and young people, so the provision of dietetic services is outside the scope of this update.
British Society of Paediatric Dentistry	Guideline	14	25	Please amend to include "and dental disease".	Thank you for comment. Dental disease was not included as a disease of interest in the review protocol (for further information please see appendix A in evidence review A). As evidence was not

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					examined, dental disease could not be added. The committee further noted that incidence of dental disease is high in people with type 2 diabetes, which is already a disease of interest. Based on stakeholder feedback, section 1.1.11 in evidence review A was amended to include dental disease as condition, that fell outside the remit of the review question, but is still important to consider.
British Society of Paediatric Dentistry	Guideline	19	8	Oral health workforce role in screening for overweight / obesity and providing support / signposting to services is perhaps under-utilised. There could be a great reach amongst the public given that dental teams are more likely to see more children / young people and adults on a more regular basis than other medical colleagues such as GPs. Training is desired and needed to increase confidence within the workforce on measurements (BMI etc) and supporting healthy discussions with children/young people/adults above a healthy weight. This could be an area of future research / development, i.e. online learning resource tailored to oral health teams, to overcome the challenges of lack of confidence and training.	Thank you for your comment. The committee are aware that some university aligned dental groups have been involved with identification and measurement of overweight and obesity, however it is unclear if this takes place across all dental practices. Additionally, it should be noted that commissioning of services is outside the remit of this guidance. To facilitate further training, the committee has provided references to resources that healthcare professionals can use to better understand how to best communicate degree of overweight and obesity.
Diabetes UK	Comments Form	General	General	Question 4 – We feel unable to make an informed response to this question without further information about when the potential consultation(s) for the other sections marked for review in this update will take place.	Thank you for your comment. It is anticipated that another discreet consultation will take place which look focus on the referral criteria for bariatric surgery, followed by the final consultation of the full amalgamated guideline.

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				We are concerned about the number of NICE consultations that can take place in similar topic areas at a similar time and the capacity of stakeholder organisations like us to respond to them. A single update covering all the questions could be preferable because it avoids having to go through the consultation process multiple times but a wider remit covering more sections would of course require more time and resource to manage. An indication of when these are expected to take place would be very beneficial to allow us to answer this question and plan and prepare for them accordingly. Ideally, we would like to get a sense of when sections of the guideline not marked for a review such as bariatric surgery and pharmacological interventions will be reviewed as there have been developments in these areas we feel should be reflected in the guidelines.	
Diabetes UK	Guideline	General	General	We feel that this guidance should signpost to the 'Type 2 diabetes: prevention in people at high risk' [PH38] as this is relevant to the section on choosing and discussing interventions as well as for those on taking and discussing measurements. It is also important that PH38 is kept updated in line with the developments of this guideline and the wider Weight Management suite as it has not been updated since 2017.	Thank you for your comment. As well as updating recommendations in the different weight management guidelines, this update also involves the amalgamation of 8 different guidelines. During the amalgamation process, NICE will consider if cross-referrals to other guidelines is required. For further information, please see scope. We will also pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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Diabetes UK	Guideline	004	009	Recs 1.1.2 – 1.1.4 and 1.2.3 – We agree with the recommendation to encourage adults with a BMI under 35kg/m2 to measure their height-to-waist ratio as it is practical and well evidenced as one of the measures for estimating central adiposity. This can then be used to assess their risks of weight-related conditions like type 2 diabetes and seek further advice from a healthcare professional where appropriate. As this puts personal responsibility on people to do the measurement themselves it is essential that its implementation comes with good support from healthcare professionals to ensure people measure their height-to-waist ratio correctly and understand their measurements. Healthcare professionals should also be encouraged to complete these measurements with their patients. We also welcome the recommendation to consider measuring height-to-waist ratio in children and young people over 5 years old as a method to predict health risks more accurately but reinforce the key point that this should be carefully handled by healthcare professionals.	Thank you for your comment. Recommendation 1.2.1 is outside the remit of the current update. This recommendation is due to be reviewed in a forthcoming update. Further updates of this guideline will examine identification of overweight and obesity and increasing uptake of weight management services (please refer to scope for further information). Your feedback will be considered during forthcoming updates of this guidance. Additionally, the committee agreed that support is a fundamental part of care and recommendation on encouraging self-measurement does state that people should also seek advice by a healthcare professional and for further assessment.
Diabetes UK	Guideline	004	016	We would suggest signposting to some of our practical resources that healthcare professionals can use to help people measure their waists correctly by themselves, like our popular 3 minute Youtube	Thank you for your comment. The rationale and impact section of the guideline has been amended to highlight the resources, including educational videos that can be used to understand how to measure waist.

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				instructional video 'How to measure your waist': https://www.youtube.com/watch?v=e4cUSNq_OY8	
Diabetes UK	Guideline	005	023	Rec 1.1.7 – We would recommend the addition of a clear and comprehensive visual aid for all the BMI cut-offs and categories for people of different ethnicities to make this information clearer as the current format may make it difficult for healthcare professionals reading the guidelines to follow in practice.	Thank you for your comment. The committee noted that currently visual aids are not available for BMI cut-offs, however there may be existing BMI charts that can be used to visually demonstrate classification ranges, however these may not necessarily take ethnicity into consideration. Developing visual aids would be outside the remit of this committee, however your comments will be considered by NICE where relevant support activity is being considered.
Diabetes UK	Guideline	006	018	It is important to avoid inadvertently fuelling stigma in both adults and children and young people with these recommendations and the corresponding public health message 'Keep your waist to less than half your height'. This may place an undue pressure on them to measure and analyse their waists without the supportive framework that healthcare professionals provide and the onus should not be on individuals to achieve the target 'less than half' figure alone if they don't currently. Communication campaigns developed to promote this measure should ensure that they also highlight and are closely linked to the services people can access for	Thank you for your comment. The committee highlighted that one of the key aims of the new recommendations is to promote a holistic approach and shared decision making during which healthcare professionals and people work together to identify methods of reaching or maintaining a healthier weight status. This has been highlighted in recommendation 1.2.15. Additionally, NICE does not have a remit to undertake national communication campaigns, however we will pass this comment on to our communications team with a view to having the information included in any press releases about this guideline.

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				support like their GP and weight management programmes.	
Diabetes UK	Guideline	006	025	Recs.1.1.11 and 1.2.6 – We agree that healthcare professionals speaking in terms of degrees of overweight, obesity and central adiposity instead of the more general clinical risk factors in discussions is a clearer way of conveying the significance and potential impact of people's weight measurements. However, to make these recommendations more effective, emphasis should be put on healthcare professionals first considering their justification for asking permission to discuss results. This should be a person-centred approach and take into account individual factors like previous experiences of accessing weight management services, age and socio-economic status. This would act as a better prompt for healthcare professionals to consider their individual patient's circumstances and approach conversations in a sensitive and constructive way, using non-stigmatising language. They should also consider the appropriateness of the measurement as it may not be suitable for all, particularly older people and those with achondroplasia. There are some practical resources explaining stigma and offering advice to reduce it that can be included here: the Obesity Health Alliance's 'Weight Stigma'	Thank you for your comment. Based on the stakeholder feedback received, the committee amended the rationale and impact section of the guideline to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				position statement and NHS England's 'Language Matters' booklet for diabetes. Reference: OHA - 'Weight Stigma' position statement (obesityhealthalliance.org.uk) NHS England 'Language Matters - Language and diabetes' (england.nhs.uk)	
Diabetes UK	Guideline	007	012	Recs 1.1.14 and 1.2.8 – We welcome this recommendation but would note the practical considerations given the uneven and inequitable access to weight management services currently. Provision of services around the UK is patchy and, as the committee is aware, incidence of type 2 diabetes and other weight-related co-morbidities is disproportionately high in people living in more deprived areas, of non-white ethnic background and living with learning disabilities who often encounter barriers to accessing services and are under-represented in them.	Thank you for your comment. The committee also agreed that there is disparity in the provision of services across the UK. Compared to previous iteration of CG189, these recommendations bring to the forefront the importance of lower BMI thresholds in people with a South Asian, Chinese, other Asian, Middle eastern, Black African or African-Caribbean family backgrounds due to the increased risk of cardiometabolic risk in these populations. While availability of resources are local implementation issues, the committee hope that this update and subsequent updates of the weight management guideline bring out positive changes in the system.
Health Equalities Group	Guidance	006	025	We agree that permission should be granted before discussing BMI results with patients. We would like to see more support and guidance on how to discuss patient's BMI results in a 'sensitive	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for

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				manner'. There is evidence to suggest that that weight bias and stigmatisation in prevalent in healthcare settings, including doctors, nurses, dieticians, psychologists and students (Pont SJ, Puhl R, Cook SR, Slusser W, Obesity SO, Society TO. Stigma Experienced by Children and Adolescents With Obesity. Pediatrics [Internet]. 2017 Dec 1 [cited 2022 Apr 21];140(6). Available from: https://www.publications.aap.org/pediatrics/article/140/6/e20173034/38277/Stigma-Experienced-by-Children-and-Adolescents) Evidence also suggests that patients who feel "judged" by their healthcare providers are less likely to be successful when attempting to lose weight (Gudzune KA, Bennett WL, Cooper LA, Bleich SN. Perceived judgment about weight can negatively influence weight loss: A cross-sectional study of overweight and obese patients. Prev Med. 2014 May 1;62:103–7). We recognise that the impact of stigma is cited in the rationale and impact statement. However, we feel that there should be more guidance supplied as part of this document to support practitioners to discuss BMI results in a 'sensitive manner'.	healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
Health Equalities Group	Guidance	009	014	We would like to see more support and guidance on how to discuss patient's BMI results in a 'sensitive manner'. There is evidence to suggest that that weight bias and stigmatisation in prevalent in healthcare settings,	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge

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				including doctors, nurses, dieticians, psychologists and students (Pont SJ, Puhl R, Cook SR, Slusser W, Obesity SO, Society TO. Stigma Experienced by Children and Adolescents With Obesity. Pediatrics [Internet]. 2017 Dec 1 [cited 2022 Apr 21];140(6). Available from: https://www.publications.aap.org/pediatrics/article/140/6/e20173034/38277/Stigma-Experienced-by-Children-and-Adolescents) We would also like to share details of a 'health-gains approach' which is currently being applied to a children's weight management service in Bolton. This approach does not focus on weight, but instead emphasises sustainable health behaviours. The aim of this approach is to help without harming, promoting sustainable health behaviours whilst being sensitive to the mental and physical risks associated with weight stigma, food restriction and weight cycling. The service is specifically designed for families with children and young people aged 12-19 years old who carry excess weight. (https://foodactive.org.uk/weight-stigma-local-case-study-a-health-gains-approach-in-a-0-19-service-weight-inclusive-practices-with-children-young-people-and-families/) We recognise that the impact of stigma is cited in the rationale and impact statement. However, we feel that there should be more guidance supplied as part of this	on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				document to support practitioners to discuss BMI results in a 'sensitive manner'.	
Health Equalities Group	Questions (above)	General	General	1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. The recommendations on discussing BMI results with patients in a 'sensitive manner' can have a significant impact on practice. We know that many healthcare professionals hold pre-existing negative bias attitudes towards people with obesity [1, 2, 3]. Experiencing stigma in healthcare settings can create a significant barrier to individuals accessing the services and support they may need and want to manage their weight. Removing this barrier by ensuring that conversations around weight are broached sensitively is likely to have a big impact on the quality of weight management services, and the number of individuals with obesity accessing these services. The challenge for implementation will be to ensure there is a consistent approach on how these conversations are broached across various healthcare settings and staff. Appropriate training is required to ensure that staff who discuss weight and BMI	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				measurements with patients do so in a way that is non stigmatising. *[1] APPG on Obesity (2018) The current landscape of obesity services: a report from the All-Party Parliamentary Group on Obesity [online] Available at: http://allcatsrgrey.org.uk/wp/download/public_health/APPGonObesity-Report2018.pdf* *[2] Tomiyama, J.A et al. (2018) How and why weight stigma drives the obesity 'epidemic' and harms health. BMC Medicine. 16 (218) https://doi.org/10.1186/s12916-018-1116-5* *[3] Puhl, R. and Brownell, K. (2006) Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults. Obesity Reviews. 14 (10).*	
Health Equalities Group	Questions (above)	General	General	2. Would implementation of any of the draft recommendations have significant cost implications?	Thank you for your comments. Since there're already training resources available to offer information about addressing issues on weight stigma and bias, the cost implications are likely to be small. In addition, as explained in your comment, such trainings could have a positive impact on the quality of care to

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				Improving current weight management services through education and training on weight stigma and bias with a view to future elimination of this prejudice can have a positive impact on the number of individuals accessing healthcare services to manage their weight. This could in turn have a positive impact on levels of overweight and obesity, and thereby reduce the associated costs of obesity on the NHS and wider system (which is estimated to be around £6bn per year). There would be cost implications for upskilling the workforce to have sensitive conversations about weight, as a result of the additional training offered, and therefore a feasibility study should be considered as a first point of action. However, costs could be lower substantially by delivering the training in-house but trusts will also get to retain that expertise to draw on throughout the rest of the time. Other cost-effective ways to deliver such training could be train the trainer approaches.	manage obesity and thereby reduce the long-term cost of obesity to the health care system. The rationale and impact section of the guideline has been amended to justify additional training costs that may be required.
Health Equalities Group	Questions (above)	General	General	3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives.)	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for

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				There is some evidence to suggest that some healthcare workers lack confidence in broaching conversations around weight with patients [4]. This perceived lack of confidence and educational resources for healthcare workers could be a significant barrier for conversations about weight are initiated with patients , and approached in a sensitive manner. As discussed in our response to question 1, offering training to healthcare practitioners that deal with weight measurements/BMI/referrals to weight management services may help to overcome some of these challenges. In addition, allowing more time for consultations with patients to discuss results may increase the chance of broaching the conversation sensitively. There is some evidence that lack of time is a barrier for GPs/practitioners in engaging patients in discussions about overweight and obesity [5, 6]. Finally, another key barrier to discussing weight with patients is the 'what next?' question and there are two	healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language. The committee further agreed that there is a shortage of weight management services. However, service provision is beyond the remit of this guideline.

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				issues that affect this. Firstly, practitioners understanding, and awareness of local referral pathways or services/support may be limited, or simply healthcare practitioners may not have clear referral criteria [7]. Secondly, the lack or shortage of weight management services is also a noted as a barrier to discussion about weight during consultations [5]. Availability of services to signpost patients to has been impacted significantly in recent weeks following the withdrawal of funding to support local Tier 2 adult weight management services. *[4] Ray, D. et al. (2022). Barriers and facilitators to implementing practices for prevention of childhood obesity in primary care: A mixed methods systematic review. Obesity Reviews. https://doi.org/10.1111/obr.13417* *[5] McHale CT, Laidlaw AH, Cecil JE Primary care patient and practitioner views of weight and weight-related discussion: a mixed-methods study BMJ Open 2020;10:e034023. doi: 10.1136/bmjopen-2019-034023*	

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				[6] Glenister, K.M. et al. (2017) Barriers to effective conversations regarding overweight and obesity in regional Victoria. Australian Family Physician. *[7] Parretti, H. and Chowhan, H. (2021) Overcoming challenges in managing obesity in primary care [online] Available at: https://d9qc22597pyja.cloudfront.net/Uploads/s/m/u/finalobesitysupplementdigitalversion_595635.pdf*	
Institute of Health Visiting	Guideline	General	General	The iHV would recommend that you include the National Child Measurement Programme to this section as children and young people as the provides an opportunity to measure the height and weight of children in Reception class (aged 4 to 5) and year 6 (aged 10 to 11), to identify risks for overweight and obesity. The NCMP guidance outlines the following: 1. Only height and weight are taken 2. BMI is used to assess obesity and the difference in gender, age, rural/urban classification, deprivation and ethnic group is taken into account 3. This data is linked to NHS Digital and PHE Obesity Risk Factors which needs to be considered 4. Letters are sent following the measurements stating if a child is a healthy weight, over-	Thank you for your comment. The National Child Measurement Programme is outside the remit of NICE and therefore the committee cannot make specific recommendations about the programme. The Office for Health Improvement and Disparities provide strategic leadership and support for this programme. However, the rationale and impact section of the guideline has now been amended to make reference to the to the NCMP operational guidance that can be used by professionals involved in measuring children and young people to understand how the clinical definitions of BMI link to BMI centiles and BMI SDs.

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				weight or obese (this is a debated point but until reviewed is what is required) NHS Digital - National Child Measurement Programme, April 2021 https://digital.nhs.uk/services/national-child-measurement-programme/#top PHE - National Child Measurement Programme: ad-hoc analysis of data, August 2021 https://www.gov.uk/government/publications/national-child-measurement-programme-ad-hoc-analysis-of-data PHE - School-aged years high impact area 3: Supporting healthy lifestyles, updated May 2021 https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/school-aged-years-high-impact-area-3-supporting-healthy-lifestyles PHE - A healthier weight - School age five to eighteen December 2019 https://khub.net/web/phe-national/public-library/-/document_library/v2WsRK3ZlEig/view_file/262823667?_com_liferay_document_library_web_portlet_DLPortlet_INSTANCE_v2WsRK3ZlEig_redirect=https%3A%2F%2Fkhub.net%3A443%2Fweb%2Fphe-national%2Fpublic-library%2F-	

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				%2Fdocument_library%2Fv2WsRK3ZlEig%2Fview%2F262823140%3F_com_liferay_document_library_web_portlet_DLPortlet_INSTANCE_v2WsRK3ZlEig_redirect%3Dhttps%253A%252F%252Fkhub.net%253A443%252Fweb%252Fphe-national%252Fpublic-library%252F-%252Fdocument_library%252Fv2WsRK3ZlEig%252Fview%252F175783630	
Institute of Health Visiting	Guideline	006	025	To add that a new narrative that avoids stigma and weight discrimination is essential if people living with excess weight are to be fully supported, and the inequities that drive ill-health are to be recognised and addressed. Turning-the-Tide-A-10-year-Healthy-Weight-Strategy.pdf (obesityhealthalliance.org.uk) Health care professionals need to be trained in weight stigma, bias and discrimination to enable them to have compassionate, sensitive and effective conversations on excess weight. In England, a survey by the All-Party Parliamentary Group (APPG) on Obesity showed that 88% of people living with obesity reported being stigmatised due to their weight: APPG on Obesity 2018 The Current Landscape of Obesity Services https://obesityappg.com/inquiries and J.M. Hunger and B. Major 2015 'Weight stigma mediates the association between BMI and self-	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				reported health' Health Psychol 34(2): 172–5 https://doi.org/10.1037/hea0000106	
Institute of Health Visiting	Guideline	007	005	To add the importance of using a personalised care approach in line with the NHS Long Term Plan: https://www.longtermplan.nhs.uk/areas-of-work/personalised-care/ Personalised care helps a range of people, from those with long term illness and complex needs through to people managing mental health issues or struggling with social issues which affect their health and wellbeing. It helps them make decisions about managing their health so they can live the life they want to live based on what matters to them, working alongside clinical information from the professionals who support them.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider how weight should be discussed, the issues around weight stigma and using sensitive language.
Institute of Health Visiting	Guideline	007	012	To add the importance of using a personalised care approach when considering a higher level of intervention in line with the NHS Long Term Plan: https://www.longtermplan.nhs.uk/areas-of-work/personalised-care/ Personalised care helps a range of people, from those with long term illness and complex needs through to people managing mental health issues or struggling with social issues which affect their health and wellbeing. It helps them make decisions about managing their health so they can live the life they want to live based on what matters to them, working	Thank you for your comment. The committee agree that a personalised care approach should be utilised. As highlighted in recommendation, 1.2.15, healthcare professionals should take into account a number of factors when discussing and agreeing level of intervention. The committee have also amended the rationale and impact section of the guideline to highlight resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity

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				alongside clinical information from the professionals who support them.	with adults, children and young people. This information has been linked to the Obesity UK's guidance on language matters which provides further information on how to discuss weight sensitively.
Institute of Health Visiting	Guideline	008	017	This particular section references children who are over the age of four. To ensure that the 2-4 year old group are not 'hidden' from practice – we would recommend highlighting the specific needs of this age group and to therefore add the following to this section: Ensure that all infants and young children at risk of, or with overweight and obesity are identified and supported. This requires height and weight measurements to be taken at 2-2.5-year check with data nationally collated, and the development of a model pathway with guidance to identify infants and key principles for future management with targeted pathways for the highest risk communities (such as looked after children and those with special education needs). Turning-the-Tide-A-10-year-Healthy-Weight-Strategy.pdf (obesityhealthalliance.org.uk)	Thank you for your comment. Based on the feedback, recommendation 1.2.21 has been amended to state that the childhood and puberty close monitoring (CPCM) can be used for longitudinal BMI monitoring in children aged 2 years and older, especially in instances where puberty is either premature or delayed. Additionally, the focus of this update is on identifying and assessing overweight, obesity and central adiposity in children, young people and adults. Further statement on frequency of measurements, as stated in your comment, cannot be added to recommendations, however, further updates of the guidelines are planned which will look into best methods of identification and your comment will be taken into consideration when evaluating this evidence. For further information, please refer to the scope.
Institute of Health Visiting	Guideline	009	017	To add a section prior to this about the importance of prevention and early identification and support of children and families.	Thank you for your comment. The committee acknowledged the points raised about the importance of prevention and early identification; however, this is out of the remit for this current update. Forthcoming updates have been planned for this guideline that will

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				The early years presents a unique opportunity to influence the future health of children and bring wider benefits to the whole family. Health visitors are uniquely placed to work alongside parents from preconception to their child starting school, to enable the adoption of healthier behaviours for their children to reduce their risk of obesity, and to support families living with obesity to think about healthy weight and nutrition and access effective interventions. The evidence is clear that families are more likely to change their behaviour if they have a trusted relationship and it takes skill to do this work well. Health visitors offer early support to children and families and prevent costly problems by identifying children at risk of excess weight early. Through their universal reach into all families with babies and young children in the UK, health visitors are in a privileged and unique position to support behaviour change – including reaching families that are considered 'hard to reach' or experience difficulties accessing services. Most parents want the best for their children, but it isn't always easy to provide a healthier home environment. To tackle the obesity crisis, and reach the vast numbers of high-risk families, practitioners need to be supported to use their time most effectively to make the biggest impact. There is strong evidence that	examine effectiveness of interventions for identification and increasing uptake of weight management services. Additionally, further work is also planned to explore the effectiveness of healthy living programmes in children and young people. For further information, please refer to the scope. Your comment will be taken into consideration when conducting future updates.

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				simplistic advice giving, or 'telling people what to do', can leave people feeling judged, more likely to disengage in support and less likely to adopt lifestyle changes. 'Poor communication' is consistently the highest recorded NHS complaint type, and practitioner's insensitive conversations with overweight people frequently hit the headlines. Conversely, treating people with dignity and respect, and equipping practitioners with both the 'key messages' and 'helper skills' to support families to make positive lifestyle improvements, can bring about lasting change. An increase in universal health visitor contacts would make available greater opportunities for the provision of advice and support on infant feeding and the promotion of healthy eating, physical activity and healthy weight. It would also enable the early identification of children at risk of unhealthy growth with enhanced, tailored follow-up where needed to improve outcomes. Evidence also indicates that, to be effective, intensive home-visiting programmes for families requiring targeted support need to include at least 6–10 visits and last for at least a year. https://www.researchgate.net/publication/242494602_Ante_and_post-natal_home-visiting_programmes_a_review_of_reviews	

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				The iHV has made a pragmatic case to increase the health visiting universal contacts from 5 to 8. iHV (2019) Health Visiting in England: A Vision for the Future: https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf which has been supported by over 50 organisations who form part of the Obesity Health Alliance OHA (2121) Turning the Tide A 10-year Healthy Weight Strategy Turning-the-Tide-A-10-year-Healthy-Weight-Strategy.pdf (obesityhealthalliance.org.uk) Responding to signals of risk for children and families before problems become more difficult to reverse, enables families to have the right care at the start, rather than trying to change deeply entrenched behaviours later in life later. Early intervention approaches which have strong evidence of impact have the potential to reduce the likelihood of poor long-term outcomes for children. This not only benefits children now and in the future, but also wider society and the economy. (Early Intervention Foundation 2021: https://www.eif.org.uk/report/the-case-for-early-intervention-to-support-levelling-up-and-covid-recovery)	

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				Recent data indicate that childhood obesity rates increased substantially between 2019/20 and 2020/21 among both reception and year 6 age children, accelerating a trend which has continued for at least the previous 15 years. Tackling rising levels of obesity and the linked cardiovascular disease risk is a public health priority and HVs through their universal reach to all families, have a significant and strategic role to play. Historic funding cuts to local authorities, have had an impact on services to support parents of young children – such as advice on healthy weight and healthy eating in the early years. Consequently, the number of children starting school with overweight, or obesity has risen: • More than 1 in 5 children in Reception (aged 4-5 years) is **overweight** or obese (boys 23.3%, girls 22.7%, all children 23.0%) • Around 1 in 10 children in Reception (aged 4-5 years) is **obese** (boys 10.1%, girls 9.7%, all children 9.9%) OHID (2022) **Error! Hyperlink reference not valid.**	
Institute of Health Visiting	Guideline	009	017	To add to this section: Support and guidance to families should be delivered in an understanding, sensitive and compassionate way, and cover multiple components and advice for	Thank you for your comment. Recommendation 1.2.28 has been amended to include social complexity (for example looked after children and young people) as a factor that needs to be considered when considering tailored interventions

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				parents should include the promotion of physical activity in line with CMO guidelines: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf Looked-after children and those with special educational needs are at higher risk so support is essential for both the individual and the whole family/caregivers so that they receive appropriate advice and guidance on nutrition and healthy eating, physical activity and consistent messages on healthy weight. Turning-the-Tide-A-10-year-Healthy-Weight-Strategy.pdf (obesityhealthalliance.org.uk)	for children and young people. The rationale and impact section has also been amended to specify children and young people in care who need to be considered when thinking about social complexity.
Institute of Health Visiting	Guideline	011	007	The iHV would recommend adding to this section about the importance of prevention and early identification and support for adults living with overweight and obesity in the preconception stage, during pregnancy and for adults who are breastfeeding/chest feeding. Pre-conception, pregnancy and the early years are ideal times to support early intervention: parents and caregivers want the best for their babies. There are many opportunities where support can be offered, such as at family planning clinics, GP and practice nurse	Thank you for your comment. As detailed in the scope of the guideline, this guideline does not cover people who are pregnant. It was also noted that recommendations drafted as part of this update would be applicable to the preconception stage. Prevention is also covered in greater detail in NICE guidance PH27 on weight management before, during and after pregnancy. Recommendations on weight management before and after pregnancy will feature in the final amalgamated guideline while weight management during pregnancy will be covered in the maternal and child nutrition guideline which is expected to publish

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				checks, health-visitor mandated contacts and the six-week postnatal check. There is clear evidence that living with overweight or obesity before or during pregnancy can influence the metabolic environment experienced by the growing foetus, which impacts on birth size and growth patterns in infancy. Z. Yu et al. 2013 'Pre-pregnancy body mass index in relation to infant birth weight and offspring overweight/obesity: a systematic review and meta-analysis' PloS One https://doi.org/10.1371/journal.pone.0061627 Poor nutritional intake (such as low iron intake) can also influence cognitive development of the baby. R. Pérez-Escamilla et al. 2017 'The role of nutrition in integrated early child development in the 21st century: contribution from the Maternal and Child Nutrition journal' Matern Child Nutr 13: e12387 https://doi.org/10.1111/mcn.12387 Studies have shown that higher pre-pregnancy weight and excessive weight gain during pregnancy are both associated with a higher risk of overweight or obesity for the child in early, mid and late childhood.	in November 2023. For further information, please refer to the scope.

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				E. Voerman et al. 2019 'Maternal body mass index, gestational weight gain, and the risk of overweight and obesity across childhood: An individual participant data meta-analysis' PloS Med 16(2): e1002744 https://doi.org/10.1371/journal.pmed.1002744 Men living with overweight, and obesity may find it harder to conceive, as excess weight can affect the quality and quantity of sperm. 8. A. Salas-Huetos et al. 2021 'Male adiposity, sperm parameters and reproductive hormones: an updated systematic review and collaborative meta analysis' Obes Rev 22: e13082 https://doi.org/10.1111/obr.13082	
Institute of Health Visiting	Guideline	014	008	Discussing the results The iHV would recommend including pregnant women/people, people who are in the preconception and postnatal period. In the 2017 Maternity Services Dataset, 49% of pregnant women attending their first appointment with a midwife were either living with overweight or obesity. Evidence shows a significant relationship between maternal obesity and the birth of babies above a normal weight range, and the subsequent development of childhood and adult obesity parental health (OHID (2022) https://www.gov.uk/government/publications/childhood-	Thank you for your comment. Reference provided were checked and were deemed outside the scope of this current update. It should also be noted that women who are pregnant, were outside the scope of this guideline. For further information, please refer to the scope. Weight management during the preconception and postnatal stage will be covered in the final amalgamated guideline while weight management during pregnancy will be covered by the maternal and child nutrition guideline which is expected to publish in November 2023.

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				obesity-applying-all-our-health/childhood-obesity-applying-all-our-health) Consideration should be given on the impact that living with overweight and obesity and the effects this can have on their baby/unborn baby. For example, women with overweight and obesity tend to have significantly lower breastfeeding rates and continue to breastfeed for a shorter period of time than women with lower pre-pregnancy weight. (N.E. Marshall et al. 2019 'Impact of maternal obesity and breastfeeding intention on lactation intensity and duration' Matern Child Nutr 15: e12732 https://doi.org/10.1111/mcn.12732 and I. Guielinckx 2012 'The effect of pre-pregnancy BMI on intention, initiation and duration of breast-feeding' Public Health Nutr 15: 840–8 https://doi.org/10.1017/S1368980011002667) Improving support to women would increase breastfeeding rates and breastfeeding continuation. There is growing evidence that breastfeeding gives a consistent protective effect against overweight and obesity in infancy (estimated as around a 20% reduction in prevalence), which lasts into childhood and adulthood.	

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				(C.G. Victoria et al. 2016 'Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect' The Lancet 387(10017): 475–90 https://doi.org/10.1016/S0140-6736(15)01024-7) B.L. Horta 2015 'Long-term consequences of breastfeeding on cholesterol, obesity, systolic blood pressure and type 2 diabetes: a systematic review and meta-analysis' Acta Paediatr 104: 30–7 https://doi.org/10.1111/apa.13133 Childhood obesity and excess weight are significant health issues for children and their families. There can be serious implications for a child's physical and mental health, which can continue into adulthood. OHID (2022) https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health	
Institute of Health Visiting	Guideline	015	024	The iHV would recommend taking into consideration current workforce shortages across all the recommendations and a national workforce plan is needed to deliver these recommendations in full. For example – Health visiting has a current workforce shortage of 5000 health visitors. There needs to be increased funding to ensure health visitors have the capacity and skill to enable healthy weight, health	Thank you for your comment. The committee acknowledged that there is a shortage of work force and that there are costs associated with training staff. Given that the annual cost of obesity amounted to be around £6.1 billion to the NHS and £27 billion to the wider economy, as calculated by the Public Health England, the extra costs are likely to be outweighed by long-term health benefits.

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				nutrition interventions and reverse the decline in health visiting numbers Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. https://bit.ly/3DSD8KE with a HV numbers	Funding is outside the remit of NICE and the work of this committee, however the committee hopes that there is a positive change in the system following the publication of these recommendations and subsequent updates of the weight management guidelines.
Institute of Health Visiting	Guideline	016	015	The iHV would recommend adding that health care professionals should use opportunistic moments to open up conversations around weight and, if appropriate, use a Royal College of Paediatrics and Child Health (RCPCH) UK growth chart or the healthy weight calculator to determine the body mass index (BMI) centile and weight status of the child or young person be mindful of weight bias, and use neutral, non-blaming, factual language when discussing weight with families OHID (2022) https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health It's not always possible to tell if a child is a healthy weight for their age, sex and height just by looking at them. Evidence indicates that parental recognition of childhood overweight is limited. This may be due to parents using visual assessments of children and comparisons with others, rather than using objective measures such as body mass index (BMI) or growth	Thank you for your comment. Forthcoming updates have been planned that will examine effectiveness of interventions for identification and increasing uptake of weight management services. For further information, please refer to the scope. Your comment will be taken into consideration when conducting future updates. Additionally, based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				charts, when determining child weight status. Parental ability to correctly identify childhood overweight in the future may become even more problematic because with increasing levels of childhood overweight at a societal level comes a shift in what constitutes 'normal' weight toward heavier weight categories: https://academic.oup.com/jpubhealth/article/40/3/582/4668752 The first step in identifying families at risk is to measure the child's height and weight. Health care professionals should use their professional judgement to determine when it is appropriate to initiate a conversation about a child or young person's weight. Keep in mind that for some children, the focus may be on weight maintenance and growing into a healthier weight, rather than weight loss, depending on age, stage of growth and degree of excess weight. Depending on whether or not the parent or carer has received information about their child's height and weight measurements already, and how they present to health care professionals should determine the most appropriate suggestion for talking about a child's weight status. PHE (2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/649095/child_weight_management_lets_talk_about_weight.pdf	

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Institute of Health Visiting	Guideline	019	005	The iHV would recommend adding to this section: The height ratio is not routinely taken in health visiting and school nursing practice. There will be a training cost implication for health visitors and school nurses as well as equipment costs, including infection control guidance. PHE – Health visiting and school nursing service delivery model, updated May 2021 https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model#health-and-wellbeing-reviews PHE – Healthy child programme 0 to 19: health visitor and school nurse commissioning, updated March 2021 https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning PHE - Early years high impact area 4: Supporting healthy weight and nutrition, updated May 2021 https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-4-supporting-healthy-weight-and-nutrition	Thank for your comments. The committee did take training costs into consideration and did note that there may be an increase in costs due to training which may put pressure on the system. However, they agreed that the training costs for health visitors and school nurses are likely to be small given a wide range of existing training programmes available for conducting the measurements and interpreting the results for children and young people. The equipment costs are likely to be small as well since tape measures are affordable and easy to obtain. In addition, there are many alternative options available as well (including using the string test which involves using a piece of string to measure the height and folding it in half to measure the waist).

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				PHE - A healthier weight – Birth to age four December 2019 https://khub.net/web/phe-national/public-library/-/document_library/v2WsRK3ZlEig/view_file/262823635?_com_liferay_document_library_web_portlet_DLPortlet_INSTANCE_v2WsRK3ZlEig_redirect=https%3A%2F%2Fkhub.net%3A443%2Fweb%2Fphe-national%2Fpublic-library%2F-%2Fdocument_library%2Fv2WsRK3ZlEig%2Fview%2F262823140%3F_com_liferay_document_library_web_portlet_DLPortlet_INSTANCE_v2WsRK3ZlEig_redirect%3Dhttps%253A%252F%252Fkhub.net%253A443%252Fweb%252Fphe-national%252Fpublic-library%252F-%252Fdocument_library%252Fv2WsRK3ZlEig%252Fview%252F175783630	
Lancashire and South Cumbria NHS Foundation Trust	Guideline	008	020	The recommendations noted referring to central adiposity based on waist to height ratio in children will be challenging for service , not currently offered & equipment and training would be needed Also this is not referred to in the National Child Measurement Programme where we only complete height and weight measurements for BMI.	Thank you for your comment. The rationale and impact section of the guideline has been amended to highlight resources that are available that can help healthcare professionals understand how waist measurements should be obtained. Additionally, the recommendations have also been amended to provide further clarity on how waist-to-height ratio should be calculated. Lastly, the National child Measurement programme is outside the remit of this guideline.
London Metropolitan University	General	General	General	Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.	Thank you for your comment. The committee did take current practice into consideration and agreed that BMI is the main measure for defining overweight and

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				Changing the mind set of healthcare practitioners in relation to focussing less on BMI and moving towards waist measurement and its incorporation into the WHtR. BMI has become ingrained in clinical thinking in relation to obesity assessment and risk. Recognising abdominal adiposity as a key risk for metabolic disease and its measurement are new concepts for many in the medical and scientific fields even in 2022.	obesity. However, the committee also noted the importance of central adiposity and understanding how this is linked to health risks.
London Metropolitan University	General	General	General	Would implementation of any of the draft recommendations have any significant cost implications? For equipment this would be minimal. Probably cost implications for the training of healthcare practitioners in the understanding of abdominal obesity and metabolic risk as well as the practical technique in conducting this measurement and its interpretation.	Thank for your comments. The committee did take training costs into consideration and did note that there may be an increase in costs due to training which may put pressure on the system. However, they agreed that the training costs for health care practitioners are likely to be small given a wide range of existing training programmes available. There is also an opportunity to incorporate the new measure into existing training courses. Given that the annual cost of obesity amounted to be around £6.1 billion to the NHS and £27 billion to the wider economy, as calculated by the Public Health England, additional costs to develop new training programmes are justified because of better health outcomes achieved in the long term. Further discussions about the cost impact have been added to the rationale and impact section of the guideline.
London Metropolitan University	General	General	General	What would help users overcome any challenges?	Thank you for your comment. The rationale and impact section has been amended to highlight the resources that are available to help people measure

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				Development of training videos on measurement technique. More public health/health education campaigns to raise awareness of waist circumference and its link to disease risk.	the waist. It should also be noted that evidence reviews A and B highlight that there are videos created by organisations such as the British Heart Foundation and Diabetes UK on how to conduct waist measurements.
London Metropolitan University	General	General	General	This partial update on 'identification and classification of overweight and obesity' relates to questions 1.1 and 1.2 within the scope of Weight management: preventing, assessing and managing overweight and obesity (update). This is considering 7 further questions and will eventually bring together a number of existing NICE guidelines into a single guideline., or you Please could you comment on whether it would useful to have further partial updates relating to some of those questions would prefer to wait and see the entire weight management pathway in one guideline. Further partial updates would be preferable as it indicates that the committee/NICE are actively engaged with ongoing work in this area.	Thank you for your comment. It is anticipated that another discreet consultation will take place which look focus on the referral criteria for bariatric surgery, followed by the final consultation of the full amalgamated guideline
London Metropolitan University	Guideline	General	General	We welcome the opportunity to comment on the draft revised guideline on obesity identification and classification on overweight and obesity.	Thank you for your comment.
London Metropolitan University	Guideline	000	020	The "thin-fat" phenotype provides evidence that even at a "healthy" BMI, visceral adiposity can be high, so we endorse this recommendation to use clinical judgement.	Thank you for your comment.

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London Metropolitan University	Guideline	000	023	The recognition that thresholds of adiposity-related metabolic risk vary across different ethnicities is supported in these guidelines.	Thank you for your comment.
London Metropolitan University	Guideline	004	010	We endorse the inclusion in clinical practice and in patient self-assessment of the waist-to-height ratio measure as an index of adiposity and metabolic risk in adults. The evidence base for this metric has grown over the last twenty years and brings to the forefront the focus on abdominal obesity as opposed to general obesity being linked with risk of ill health.	Thank you for your comment.
London Metropolitan University	Guideline	005	002	We wish to endorse the statement interpretation of BMI with caution despite it being a practical measure.	Thank you for your comment.
London Metropolitan University	Guideline	006	004	Whilst it is true that BMI may be less accurate in persons with a high muscle mass, equally those, with a low muscle mass may be incorrectly classified by BMI as having a healthy adiposity. This is a further reason why WHtR should be routinely assessed in those within the normal BMI range.	Thank you for your comment. The committee did take inaccuracy of BMI in measuring adiposity into consideration when drafting recommendations. Recommendation 1.2.7 does state that clinical judgement should be used when interpreting the healthy weight category because a person in this category may nevertheless have central adiposity.
London Metropolitan University	Guideline	006	007	The committee could consider including a statement relating to the interpretation of BMI in over 65s with respect to possibility of low muscle mass, sarcopenia and sarcopenic obesity, especially within a healthy BMI range.	Thank you for your comment. The committee agreed that low mass, sarcopenia and sarcopenic obesity are important factors to be taken into consideration and that healthcare professionals should be cautious when interpreting BMI in older people aged 65 and over. It was further noted that while recommendation 1.2.10 does not specifically list sarcopenia or sarcopenic obesity as factors that need to be taken into consideration, the recommendation does include

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					functional capacity, which can be affected if a person has sarcopenic obesity. The rationale and impact section of the guideline has been amended to provide further clarification.
London Metropolitan University	Guideline	006	010	We endorse the proposed boundary values and the recognition of the validity of this metric in highly muscular individuals.	Thank you for your comment.
London Metropolitan University	Guideline	008	011	We endorse the guidance on interpreting BMI with caution when used in children. The potential for misclassification remains with this metric, particularly the inclusion of children with excess adiposity within the "healthy" BMI-for-age range.	Thank you for your comment. Recommendation 1.2.24 has been amended further to highlight that clinical judgement should be used when interpreting the healthy weight category in children and young people as central adiposity may be present.
London Metropolitan University	Guideline	008	020	We strongly welcome the proposal in the draft guidelines to consider the WHtR in children and young people aged over 5 y. This is an overdue recognition of the role of abdominal adiposity with markers of metabolic risk in this age group.	Thank you for your comment.
London Metropolitan University	Guideline	009	002	We support the proposed boundary values.	Thank you for your comment.
National Pharmacy Association	Guideline	004	004	Include community pharmacists through various pharmacy services including healthchecks	Thank you for your comment. Recommendation 1.2.1 is outside the remit of the current update. This recommendation is due to be reviewed in a forthcoming update. Further updates of this guideline will examine identification of overweight and obesity and increasing uptake of weight management services (please refer to scope for further information). Your feedback will be considered during forthcoming updates of this guidance.

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					Additionally, based on stakeholder feedback, the committee did acknowledge that community pharmacies have been involved in conducting measurements. This has now been reflected in the rationale and impact section of the guideline.
National Pharmacy Association	Guideline	006	007	It may be helpful to include some further guidance to support with the interpretation of BMI and then discussing the results with the person.	Thank you for your comment. Due to the limited evidence identified in older people, the committee were unable to draft further recommendations for this population. This includes recommendations on specific BMI categories and interpretation in this population and the interpretation However, the committee noted that further research is required to facilitate further development of recommendation. Based on this understanding, the committee have included older people as an important subgroup in the research recommendation. Appendix L in the evidence review has been amended to include older people as a subgroup.

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National Pharmacy Association	Guideline	006	025	Suggest reference specific EDI resources	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
National Pharmacy Association	Guideline	007	005	It would be useful that a multi-disciplinary approach is adopted when it comes to interventions. Include all healthcare settings including community pharmacy. It should all be about patient choice and accessibility.	Thank you for your comment. Interventions for the management of overweight and obesity was outside the remit of this update. However, CG189 does include recommendations which endorse a multidisciplinary approach to weight management. The rationale and impact section has also been amended to highlight that community pharmacies have also been involved in taking measurements. The committee also acknowledged the importance of patient choice and agreed that it was important to ask permission before talking about the degree of overweight, obesity and central adiposity. Additionally, it was noted that a shared decision should be reached when agreeing the level of intervention required.

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National Pharmacy Association	Guideline	013	019	The issue of stigma ought to be investigated and discussed further. If we are to address the issue around obesity, a better understanding of the stigma associated needs to be researched.	Thank you for your comment. The committee did take stigma into consideration when drafting recommendations. Full discussion is highlighted in evidence review A and B. In terms further research, further work is planned for this guideline that will be looking at effective psychological approaches to deal with weight stigma. For further information on future updates, please see scope.
National Pharmacy Association	Guideline	015	002	Define *higher level* treatment.	Thank you for your comment. Recommendation 1.2.16 signposts to recommendations which focus on higher level of interventions that can be offered to people with weight-related comorbidities.
National Pharmacy Association	Guideline	015	015	It may be work researching and seeking evidence from countries such as America and Canada. Also include any specific interventions that took place in all primary healthcare settings including community pharmacy.	Thank you for your comment. The evidence review included evidence from a range of countries and settings (including general practices, community based and hospital settings). Further details are available in each study's evidence table in Appendix E of the evidence review A.
National Pharmacy Association	Guideline	015	019	Is community pharmacy included in the definition of an NHS clinical setting? If not please include or introduce a definition at the outset of the guideline.	Thank you for your comment. The scope of the guideline does highlight who this guideline is aimed towards.
National Pharmacy Association	Guideline	015	020	All pharmacies are now healthy living pharmacies where staff are trained to provide lifestyle advice and appropriate signposting. This includes the measuring of waist circumference. Suggest include all healthcare settings.	Thank you for your comment based on stakeholder feedback, the committee acknowledged that community pharmacies have been involved in conducting measurements and providing lifestyle advice. This has now been reflected in the rationale and impact section of the guideline.

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National Pharmacy Association	Guideline	015	027	The NPA suggests that costs ought not to pre-determine clinical intervention. The benefit (return of investment) of Public health interventions such as those related to obesity are realised in the long-term. Suggest re-phrase of lines 27-30 to avoid misinterpretation and unintended consequences on those living with obesity.	Thank you for your comment. The rationale has been amended as suggested to emphasise the long-term cost savings associated with a reduction in obesity-related conditions.
National Pharmacy Association	Guideline	016	020	It may be worth including the young person with other long-term conditions such as type 1 diabetes.	Thank you for your comment. The committee noted that the prevalence of overweight and obesity in the type 1 diabetes population is the same as the general population, therefore the committee did not consider type 1 diabetes as a separate subgroup. The committee further stated that the rationale and impact section already states that sensitivity is needed about the possible negative impact on children and young people with conditions such as eating disorders or disordered eating, which are prevalent in type 1 diabetes population.
Neonatal and Paediatric Pharmacists Group	Guideline	General	General	Obesity results in physiological changes that can affect the volume of distribution and the clearance of drugs. The extent of these changes is variable and depends upon both patient-specific factors and the physico-chemical properties of the drug. Medicines in children are traditionally dosed according to their body weight or age, as a surrogate of 'normal' size and function. However, as the increase in weight	Thank you for your comment. Pharmacological interventions were outside the remit of this update which focused specifically on identifying and assessing overweight and obesity in adults, children and young people. For further information on the scope of the update, please see final scope. It should be noted that currently an update is not planned for recommendations on pharmacological interventions in children and young people. We will pass your

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				in children living with obesity is not composed of similar proportions of fat and lean tissue, there is a risk of overdose if total body weight is used during weight-based dosing of certain drugs. The Neonatal and Paediatric Pharmacists Group (NPPG) recommends that healthcare professionals should be made aware that some medicine doses need to be reviewed in obese children; which adds weight to why overweight and obesity needs to be assessed in children and young people. NPPG and the Royal College of Paediatrics and Child Health (RCPCH) have worked with UK Medicines Information (UKMi) pharmacists to produce a review on how to calculate medicine doses in children who are obese, which includes a table on commonly prescribed medicines. This review is available via the Specialist Pharmacy Service (SPS) website https://www.sps.nhs.uk/articles/how-should-medicines-be-dosed-in-children-who-are-obese/	comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
NHS England and NHS Improvement	Guideline	006	026	Repeated word 'in'	Thank you for your comment. This recommendation has been amended.
NHS England and NHS Improvement	Guideline	008	009	The measurements and classification of obesity in children could be improved by consideration/description of evidence related to ethnic groups (as described under 1.1.7 for adults and observed difficulty documented on page 17 lines 13-15).	Thank you for your comment. As highlighted in the rationale and impact section of the guideline, there was a lack of evidence on boundary values for children and young people from different ethnicities. The committee were unable to draft recommendations for CYP from different ethnic

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					backgrounds but have drafted a research recommendation to further facilitate research in this area.
NHS England and NHS Improvement	Guideline	015	016	While cost analysis takes into account the cost of training extra staff for measurements and learning about identification and management of weight or obesity, it does not take into account the impact it might have on primary care staff and their time for the advice and support people will need following such measurements.	Thank you for your comment. The committee agreed that there will be an increase in staff time to give advice to people with overweight and obesity. Given that the annual cost of obesity amounted to be around £6.1 billion to the NHS and £27 billion to the wider economy, as calculated by the Public Health England, the extra costs for additional consultation time are likely to be outweighed by long-term health benefits. This has been added to the discussion in the rationale and impact section.
NHS England and NHS Improvement	Guideline	016	006	We agree that people with learning disabilities will need additional support, however, older age people, people in care home and housebound people may also need special considerations.	The committee agree that people who are housebound may require specialist equipment, but home visit service is lacking. This has been highlighted in the rationale and impact section of the guideline and section 1.1.11 in evidence review A. However, care homes are much better equipped for assessing the weight of people in their facilities. This has been added to the rationale and Impact section and section 1.1.11 in evidence review A. These groups have also been included as important subgroups in the research recommendation due to the lack of evidence identified in this population (See Appendix L in evidence review A).

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NHS England and NHS Improvement	Guidelines	General	General	Guidelines highlight the impact of improved identification of people who require interventions but there is risk that it will increase burden and workload on specialist care services and might lead to unmet demand for dietitians.	Thank you for your comment. The committee agreed that the recommendations might lead to an increasing burden and workload on specialist care services and dietitians, but these costs are justified by health benefits achieved in the long term.
NHS England and NHS Improvement	Guidelines	General	General	Guidelines are helpful in highlighting practical aspects of identification and classification of overweight and obesity, the opportunity related to this subject offered by these guidelines could be enhanced by additional considerations about ways of encouraging people to come forward and engage with the screening and assessment interventions.	Thank you for your comment. The focus of this update was on identifying and assessing overweight and obesity in adults, children and young people. Further updates have been planned for this guideline, including a review on effective approaches for identifying overweight and obesity in adults, children and young people and increase their uptake of weight management services. For further information, please refer to the scope.
NHS England and NHS Improvement	Guidelines	017	003	Guidelines provides considerations special growths charts for people with cognitive and physical impairment but there are no considerations documented about ethnicity.	Thank you for your comment. As highlighted, there was a lack of evidence on boundary values for children and young people from different ethnicities. Due to this the committee were unable to draft specific recommendations for BMI boundary values in children and young people from different ethnicities but did draft a research recommendation to facilitate further research in this field.
NHS England and NHS Improvement	Guidelines	018	020	Guidelines do not provide considerations about role of schools in supporting interventions for weight loss in children.	Thank you for your comment. Weight management programmes in children and young people were outside the remit of the current review. This will be covered in future updates of the guideline which includes review of evidence for weight management

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					programmes in children and young people. For further information, please refer to the scope.
NHS England and NHS Improvement	Guidelines	019	001	While cost analysis takes into account the costs for training, it does not take into account the additional time will take for primary care staff to implement such measures. It also does not consider role of school and education authorities in supporting implementations of recommended plan.	Thank you for your comment. The committee agreed that there will be an increase in staff time to give advice to people with overweight and obesity, as well as a potential burden on school and education authorities. Given that the annual cost of obesity amounted to be around £6.1 billion to the NHS and £27 billion to the wider economy, as calculated by the Public Health England, the extra costs for additional consultation time are likely to be outweighed by long-term health benefits. Additionally, it should be noted that national measurement programmes, such as those that occur within school setting are outside the remit. However, committee did acknowledge school nurses may be involved in taking measurements.
NHSE	Guideline	General	General	In all aspects of the document there needs to be reference to the need to make reasonable adjustments - in assessments, discussion, interventions etc - for people with a learning disability and autistic people. Some reasonable adjustments to consider include:	

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				• seated or hoist scales, or scales that will accept a wheelchair • measuring height with a tape measure • measuring height with a rollameter • measuring height with the person lying down (from NHS website)	
NHSE	Guideline	General	General	We are concerned there is no specific reference to the prevalence of obesity in people with a learning disability. Please add specific reference to the prevalence of obesity in people with a learning disability. There is evidence here on the higher rates of prevalence : https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance [accessed on: 25/05/22]. Here is a section from the website "The most recent data on the prevalence of excess weight in people aged 18 and older with learning disabilities is based on	

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				analysis of data from GPs across the whole of England. This showed that, in comparison to the general population, a smaller proportion of people with learning disabilities are in the milder category termed 'overweight' (27% of people with learning disabilities compared to 31.8% of people without a learning disability). However, there are higher proportions in the more severe category of obese (37% of people with learning disabilities compared to 30.1% of people without learning disabilities)."	
NHSE	Guideline	General	General	The British Dietetic Association (BDA) cautions that chronic constipation is a frequent problem for people with learning disabilities and this can distort assessing their weight. In addition, BMI is not always an appropriate measure for people with atypical body shape and there can be challenges in measuring height and weight accurately for some individuals (https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance)	

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NHSE	Guideline	General	General	The phrase "overweight and obesity" title (and its use throughout) isn't grammatically correct. It reads oddly, because "overweight' is generally used as an adjective in English but "obesity" is a noun. However, in American English, overweight is used a noun https://www.collinsdictionary.com/us/dictionary/english/overweight	
NHSE	Guideline	General	General	We suggest more emphasis is placed on being aware of the possible triggering effect of talking about weight for those who either have an eating disorder or who may develop one. Children and young people are particularly vulnerable. Need to recognise that someone who is overweight may have an eating disorder (bulimia or ARFID) and so conversations need to be especially sensitive. It is mentioned on p16 but perhaps should be flagged earlier in the guidance.	
NHSE	Guideline		1.1.11 to 1.1.14	There is no mention here of those with a learning disability, who may a. need reasonable adjustments for the discussion b. may have rare genetic/congenital syndromes that predispose to being overweight, and so the discussion needs to be tailored round that with good understanding of any underlying condition.	

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				Prader-Willi syndrome is well-known about, but there are hundreds of other chromosome deletions/duplications and metabolic syndromes, some of them very rare, in which overeating, or predisposition to weight gain, are inherent.	
NHSE	Guideline	Page 8	1.2	In the section on children and young people: a. In clinical practice, when treating young people with an eating disorder, we tend to use %weight for height rather than BMI because (as noted) it is not entirely reliable in under-18s) I feel that there should be more emphasis on the use of %weight for height paediatric charts. b. Sames issue about those with a learning disability as mentioned above	
NHSE	Guideline	Page 6 – 8	1.1.1 and 1.2.6	We are not sure that "ask permission" to discuss is sufficient. Consider strengthening this to include proper mention of Gillick competence, assessment of capacity etc.	
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	**Pharmacological interventions** **Could we kindly mention the level of safety regarding using Orlistat alongside Antipsychotics and/or Antidepressants as well as the safety in using Orlistat long term under these circumstances**. – This is one of the barriers I have	Thank you for your comment. Pharmacological interventions were outside the remit of this update. CG189 does currently state that in children younger than 12 years, prescribing must be started and monitored in specialist paediatric settings but does not currently highlight the issue of safety. We will

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				found in my area of work when encouraging the use of medication for weight management. I do have evidence that Orlistat can be a very useful tool for some of our inpatients but it has to be use as a long term treatment. I would like for us to be able to use medication for weight management with greater confidence and hence I am requesting your consideration in adding this to the Guidelines.	pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	**Continued prescribing and withdrawal** **Rates of weight loss may be slower in people with type 2 diabetes, so less strict goals than those for people without diabetes may be appropriate. Agree the goals with the person and review them regularly. [2006]** – Could we add here that less strict goals should also be considered for patients with severe mental health illness (SMI) and those on antipsychotic and/or antidepressant medications? I have found in my patient population the weight loss is slow but progressive and we could do with less strict goals for the prolonged used of weight management medications (namely Orlistat).	Thank you for your comment. Continued prescribing and withdrawal was outside the remit of this update. For further information on the updates planned for this guideline, please see the scope for this guideline. It should be noted that currently an update is not planned for recommendations on continued prescribing and withdrawal in adults, children and young people. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. We will also consider people with severe mental health illness during the development of the guideline.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	General	General	**Surgical interventions** Could we add here that consideration should be given to the mental health of the patient as well as their ability to selfcare post surgery.	Thank you for your comment. CG189 does include recommendations on follow up care post bariatric surgery. This recommendation specifies that people who have had bariatric surgery should be offered tailored psychological support for a minimum of 2 years within the bariatric service.

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					This section were outside the remit of this update. For further information on the updates planned for this guideline, please see the scope for this guideline. It should be noted that currently an update is not planned for recommendations on follow-up care post bariatric surgery.
Novo Nordisk	guideline	General	General	1. Novo Nordisk welcomes the development of the draft guideline on *Obesity: identification and classification of overweight and obesity*, and the update of the suite of NICE weight management guidelines. As per the guideline scope[1] we understand four areas will be reviewed: (1) identification and assessment; (2) individual-level approaches for prevention of excess weight, weight loss, and maintaining a healthy weight; (3) whole system approaches; and (4) care pathway and service delivery. As per question four above, we assume this draft guideline is focused exclusively on identification and assessment, and a separate draft guideline will follow to update and / or amalgamate the other areas for consideration, as it does not appear that these have considered in this update, nor the totality of the draft questions in the guideline scope (pp. 25-26) been answered. We would welcome clarity on the process, including the number of individual guidelines to be created or updated and associated timelines for consultation and	Thank you for your comment and for sharing your thought and concerns about NICE consultations. It is anticipated that another discreet consultation will take place which look focus on the referral criteria for bariatric surgery, followed by the final consultation of the full amalgamated guideline. As highlighted in the scope, the final amalgamated guideline will bring together 8 different NICE guidelines. Remaining updates will focus on: • effective and cost-effective approaches for identifying overweight and obesity in adults, children and young people and increasing uptake of weight management services • effectiveness and cost-effectiveness of total/ partial diet replacements, intermittent fasting, plant-based and low carb diets • What referrals criteria for bariatric surgery are most effective to achieve weight loss • Effectiveness, cost-effectiveness, and acceptability of weight management programmes • Effectiveness and cost-effectiveness of healthy living programmes

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				publication. For completeness, we believe that one consultation on the entire weight management pathway would be preferable to partial updates. [1]National Institute for Health and Care Excellence, Guideline scope Weight management: preventing, assessing and managing overweight and obesity (update). Available from: https://www.nice.org.uk/guidance/gid-ng10284/documents/final-scope	• Effectiveness, cost-effectiveness, and acceptability of psychological approaches to address the counterproductive effect of weight stigma
Novo Nordisk	guideline	004	009	2. Recognising the limitations of body mass index (BMI) as a measure for interpreting overweight or obesity, in principle Novo Nordisk welcomes the addition of the waist-to-height ratio. With one in four adults living with obesity in the UK[1], we also welcome the creation of a simple public health message that can support people to self-identify and assess whether they may be at increased health risk based on these measurements. However, we are concerned that calculating and interpreting a waist-to-height ratio could introduce additional complexity. We fear that it could risk placing greater onus on the individual, as the recommendation proposes that individuals who healthcare professionals consider as having a BMI below 35 kg/m² should be encouraged to measure their own waist-to-height ratio and seek further clinical advice if at increased risk.	Thank you for your comment. While recommendations do state that people with BMI less than 35 kg/m^2 should be encouraged to self-measure using waist to height ratio, the recommendations do also state people should also seek advice by a healthcare professional and for further assessment. Recommendations also state that in adults whose BMI is below 35 kg/m², healthcare practitioners should measure and use waist-to-height ratio, as well as BMI, as a practical estimate of central adiposity. Therefore, the onus is not on the individual but promotes a collaborative approach. NICE also have further updates planned which will examine to effectiveness of identification in adults, children and young people. For further information, please refer to the scope. Your comments will be

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				Unless individuals proactively measure and raise their BMI with their healthcare professional, or it is measured as part of a specific health check, it is not clear how healthcare professionals can identify those with a BMI below 35 kg/m² to encourage self-estimation, or whether additional resources are required for healthcare professionals or people living with excess weight to build confidence in taking these measures. A recent survey of 1,500 people living with obesity and 306 healthcare professionals found that people living with obesity initiated 47% of discussions about weight, with 65% reporting that they like their healthcare professional bringing up weight during appointments[2]. Compounded by research that many people living with obesity do not present to their healthcare professional for support with their weight, we are concerned this recommendation could miss the opportunity to identify and support those living with obesity class I, and those living with excess weight who may be at risk of obesity and additional health risks (BMI 25 kg/m² to 29.9 kg/m²; or BMI 23 kg/m² to 27.5 kg/m² for those with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background). As such, we recommend that greater emphasis is placed on identifying opportunities to initiate sensitive	taken into consideration when conducting future updates.

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				discussions about weight, and weight management to increase access to information and support. [1] NHS. Obesity overview. Available from: **Error! Hyperlink reference not valid.** [2] Hughes CA, Ahern AL, Kasetty H, et al Changing the narrative around obesity in the UK: a survey of people with obesity and healthcare professionals from the ACTION-IO study. BMJ Open 2021;11:e045616. doi: 10.1136/bmjopen-2020-045616	
Novo Nordisk	guideline	004	011	3. Adults with a BMI below 35 kg/m² are encouraged to 'seek further clinical measurements', but the draft guideline does not describe what these clinical measurements are. We would recommend these are defined in this section.	Thank you for your comment. The committee highlighted that further clinical assessment should include a cardiometabolic risk factor assessment and healthcare professionals may want to confirm the waist-to-height ratio. Recommendation 1.2.2 has been amended to further expand what committee meant by 'further clinical measurements. Additionally, Section 1.3 in CG189 further elaborates on the assessments that should be made. For example, recommendation 1.3.6 highlights that measurements should be taken to assess the degree of overweight or obesity and then assess factors such as any presenting symptoms, comorbidities (such as type 2 diabetes and cardiovascular disease) and risk factors assessed using lipid profile.

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Novo Nordisk	guideline	007	005	1. Novo Nordisk strongly supports the recommendation to introduce shared decision-making to support people living with obesity to make an informed decision about their care, especially in light of a recent survey commissioned by Novo Nordisk of 1,521 adults living with obesity in the UK[1] which found that 40 per cent were 'not at all aware' of NHS weight management services. [1] Novo Nordisk commissioned Market Research, Branding Science, Obesity Services Engagement Phase 1. 2021. Available upon request.	Thank you for your comment.
Novo Nordisk	guideline	007	008	8. Sections 1.1.13, 1.2.7 and 1.2.8 signpost to CG189 for recommendations on appropriate weight management interventions, including pharmacological interventions. We understand CG189 will be reviewed as part of a future update, and while we are disappointed that the section on pharmacological interventions will not be reviewed despite the publication of the NICE technology appraisal guidance (TAG) for liraglutide for managing overweight and obesity[1] – the first medicine approved for the treatment of obesity in over a decade – we believe that reference to liraglutide 3.0mg, or cross-reference to the TAG, should be made to section 1.3 in CG189. In collaboration with people living with obesity, this would help facilitate an informed discussion and decision about the range of interventions available. This is in	Thank you for your comment. Pharmacological interventions are outside the scope of this guideline. However, the final guideline will involve the amalgamation of 8 different NICE guidelines and during this process cross-referrals to technology appraisals will be considered. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date

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				line with section 8.1 of the NICE process and methods guide[2]. [1] National Institute for Health and Care Excellence, (2020), Liraglutide for managing overweight and obesity (TA664). Available from: https://www.nice.org.uk/guidance/ta664 [2]National Institute for Health and Care Excellence, (2022), Developing NICE guidelines: the manual. Available from: https://www.nice.org.uk/process/pmg20/chapter/introduction	
Novo Nordisk	guideline	007	012	1. In addition to recommending that a higher level of intervention should be provided to people with weight-related comorbidities, we suggest a higher level of intervention is also considered for those whose waist-to-height ratio indicates higher central adiposity (0.6 or more) in light of the increased health risks for this cohort of patients.	Thank you for your comment. The committee noted that in practice, people with comorbidities are not offered appropriate treatment early enough. The committee further noted that groups of people such as those newly diagnosed with type 2 diabetes and those with BMI over 50, may not necessarily require waist-to-height ratio to be calculated to determine health risks. In the case of such groups, immediate action needs to be taken. Based on stakeholder feedback, recommendation 1.2.16 was amended to remove reference to waist-to-height ratio to keep focus on the issue of comorbidities.

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Novo Nordisk	guideline	007	012	7. In addition to recommending that a higher level of intervention should be provided to people with weight-related comorbidities, we suggest this recommendation should also propose to 'consider a referral to tier 3 services' if the underlying causes of overweight or obesity need to be assessed; the person has severe or complex obesity and cannot be managed in tier 2; other treatment has been unsuccessful; or specialist interventions may be required. We suggest a cross-reference could be made to NHS England's report on joined up clinical pathways for obesity (pp. 15 – 16) for more information on tier 3 services[1] [1] NHS England, (2014) Report of the working group into: Joined up clinical pathways for obesity. Available from: https://www.england.nhs.uk/wp-content/uploads/2014/03/owg-join-clinc-path.pdf	Thank you for your comment. Referral to tier 3 services is highlighted in recommendation 1.3.7 in CG189.
Novo Nordisk	guideline	007	016	5. Novo Nordisk welcomes the recommendation to offer a higher level of intervention to people living with weight-related comorbidities, regardless of their waist-to-height ratio. Line 16 signposts to CG189 for details of comordbidities, but in the relevant section of CG189 (section 1.3), it is proposed that 'any comorbidities' should be assessed. As such, we would suggest removing the redirection to CG189 or clarifying the comorbidities of importance in this guideline to reduce the need to cross-reference.	Thank for your comment. The committee opted to retain cross reference to section 1.3 as the recommendation provides useful examples of comorbidities.

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Novo Nordisk	guideline	008	011	9. As BMI may not accurately assess growth or changes in body composition over time[1] we are concerned that the introduction to *measures of overweight and obesity in children and young people* (section 1.2.2) could be misread to suggest BMI in adults is the same as BMI in children, particularly because both adults and children are considered in one guideline. We recommend, therefore, that either reference to the Royal College of Paediatrics and Child Health UK-World Health Organisation (WHO) growth and BMI charts are introduced first, or some additional clarification is made to indicate that BMI should be interpreted differently for children and young people. [1]Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. BMJ 2000;320:1240-1243	Thank you for your comment. Recommendation 1.2.21 has been amended that specify that BMI should be used as a practical measure of overweight and obesity, but healthcare professionals should ensure that charts and calculations used are specific to children and young people are adjusted for age and sex. The rationale and impact section has also been amended to highlight that BMI should not be interpreted the same way as adults.
Nutrition Advice for Health – Community Interest Company	General	General	General	No Comment	Thank you for this information.
Obesity Group of the British Dietetic Association	Guideline	General	General	We would also like to highlight the importance of the tone and language used, particularly with children, to avoid potential stigma. We would advocate the use of People First language and non-stigmatising images	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge

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				(e.g. from World Obesity Image Bank) in all written communications.	on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
Obesity Group of the British Dietetic Association	Guideline	004	010	We are unclear why a BMI in adults of 35kg/m^2 is the trigger point for clinical action, when it is defined as BMI at or above 27.5 or 30kg/m^2, depending on the ethnicity of the individuals.	Thank you for your comment. This recommendation (1.2.2) focuses on the population where waist-to-height ratio is useful. This is further explained in recommendation 1.2.5 and the committee highlight in the rationale and impact section that waist-to-height ratio offers a truer estimate of central adiposity by using waist circumference in the calculation. In recommendation 1.2.2 the trigger point for further clinical assessment is not adults of 35kg/m^2 but for those below 35kg/m^2 who have measured their own waist- to- height ratio and have found this to be over 0.5.
Obesity Group of the British Dietetic Association	Guideline	004	010	We agree with the principle that adults with a BMI below 35kg/m^2 should be encouraged to assess their own degree of clinical risk and to seek healthcare professional support it they have indication of increased risk, with the proviso above (since a BMI of 30 or 27.5 and above is associated with clinical risk, depending on ethnicity). Previously waist circumference was recommended to assess central	Thank you for your comment. The committee did take this into consideration and noted that errors in measurements may occur. The same can also apply to BMI measurements which also require 2 different measures to be taken. The committee also noted that a number of clinical measurements such as weight, blood pressure and blood sugar levels are now being reported by patients due to appointments occurring

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				adiposity, but we note the new recommendation to use waist-to-height ratio. We understand the rationale for this (as accurate as waist circumference, equates to a simple message to keep waist less than half of height and with similar cut-off points for different ages, genders and ethnicities). However, we are also conscious that inaccuracies in measurement may mean either under or over estimation of risk, and with two measurements to take, the risk of error is higher.	remotely. While these measurements do involve the patient using tools such as scales and blood pressure machines, but there is still an issue with veracity. Based on stakeholder feedback, the committee agreed that further guidance was necessary to help professionals and people understand how to accurately measure and calculate waist-to-height ratio. The recommendations have been further amended to highlight how to accurately measure the waist circumference and how to calculate waist-to-height ratio. The committee further hope that even over-estimation of waist-to-height ratio may encourage people to start thinking about central adiposity and approaching healthcare professionals to discuss health risks associated with central adiposity further.
Obesity Group of the British Dietetic Association	Guideline	005	002	We agree that BMI is a practical measure but must be assessed with caution since it is indirect.	Thank you for your comment.
Obesity Group of the British Dietetic Association	Guideline	005	005	We note the recommendation that healthcare professionals use waist-to-height in place of waist circumference to assess risk, and we would like to flag the risk of measurement errors given that two measures are involved.	Thank you for your comment. The committee did take this into consideration and noted that errors in measurements may occur. The same can also apply to BMI measurements which also require 2 different measures to be taken.

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					To minimise this risk, training is essential. The committee noted that while there are no established training programmes of waist-to-height ratio there are resources available that explain how waist measurements should be taken. The recommendations provides details on how waist measurements should be conducted. The recommendations have now been amended further to highlight how waist-to-height ratio should be calculated. Additionally, the rationale and impact section of the guideline has been amended to highlight other resources which are available that can help healthcare professionals and people to understand how waist measurements should be conducted.
Obesity Group of the British Dietetic Association	Guideline	005	005	We also note that previous guidance for healthcare professionals was to measure waist circumference in adults with BMI<35kg/m2 to assess central adiposity (and this clinical risk); however, this was not often carried out in practice. Attitudes and barriers to measuring waist circumference need exploring to overcome this.	Thank you for your comment. During committee discussions, it was highlighted that one of the key barriers to waist measurement is that it is not carried out often enough and there is no space dedicated to recording waist measurements on medical notes system. However, based on the evidence and their understanding, committee believed it was important that WHtR measurement is conducted to assess central adiposity. Suitability of these measures was explored as part of the review question, but evidence was not identified. However, other review questions do focus on the barriers and facilitators to identification and uptake of weight management

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					services, which will provide more insight into the attitudes of people and healthcare professionals involved in identification. We are also aware that stigma is a barrier, which we will be exploring throughout the guideline.
Obesity Group of the British Dietetic Association	Guideline	005	020	We agree that a BMI within the healthy range does not necessarily equate with good health, and clinical judgement is needed.	Thank you for your comment.
Obesity Group of the British Dietetic Association	Guideline	005	023	We agree that lower BMI threshold points should be used to define risks for those of South Asian, Chinese, other Asian Middle Eastern, Black African or African-Caribbean family background. We are delighted to see this entering the recommendations as it is something we have advocated for some time. The effect of ethnicity in the children and young people section p8 is unclear.	Thank you for your comment. As highlighted in the rationale and impact section, there was a lack of evidence identified on BMI boundary values for children and young people from different ethnicities. Due to the lack of evidence, the committee were unable to draft specific recommendations but did draft a research recommendation to further facilitate research in this field.
Obesity Group of the British Dietetic Association	Guideline	006	001	We would like the actual cut-off points for class 2 and 3 obesity to be defined for people of these ethnicities (similar to the general recommendations on pg 5 lines 15-19). It will be more useful for healthcare professionals to have the actual cut-off points for different groups specified than to have to calculate it.	Thank you for your comment. As evidence was not identified on thresholds for obesity classes 2 and 3 in people of different ethnic backgrounds, the committee were unable to provide specific thresholds for the different obesity classes. However, the committee were aware that in practice, usual advice is to reduce the thresholds used for the general population by about 2.5 kg/m^2. The committee wanted to retain this message in the recommendation, but the rationale and impact section has been amended to provide estimates for

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					obesity classes 2 and 3 in people from different ethnicities. The committee also drafted the research recommendation to further drive research in the field.
Obesity Group of the British Dietetic Association	Guideline	006	004	We agree that caution is needed in those with high muscle mass. However, we note that BMI should never be used as the sole assessment of risk but within a holistic approach, allowing accurate clinical judgements to be made.	Thank you for your comment. The committee took this into consideration when drafting recommendation and highlighted that BMI should be used as well as waist to height ratio.
Obesity Group of the British Dietetic Association	Guideline	006	010	We agree that the simplicity and wide applicability of the 'keep waist to less than half your height' message is very attractive. However, we would like to see this recommendation assessed in practice to understand to what extent it is actually adopted, and how accurate the measurements taken are.	Thank you for your response. The uptake of the recommendations will be considered by the NICE adoption and impact team.
Obesity Group of the British Dietetic Association	Guideline	006	025	We agree that permission should be requested and given before results are discussed, and this must be done sensitively.	Thank you for your comment.
Obesity Group of the British Dietetic Association	Guideline	006	028	We understand the rationale for this change. We support the distinction made between obesity, overweight and central adiposity as well as the improved clarification of health risks.	Thank you for your comment.
Obesity Group of the British Dietetic Association	Guideline	007	005	We agree that treatment should be tailored to the level of clinical need and the individual, which will only be possible if assessment is thorough and holistic. We also support individuals having a say in decisions about their own care.	Thank you for your comment.

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Obesity Group of the British Dietetic Association	Guideline	007	012	We agree with the principle that the level of intervention should be matched with the level of need, and that existence of co-morbidities indicates increased need. However, it is our view that there are implications for training in relation to this and resources to help healthcare workers assess level of need are needed.	Thank for your comments. The committee agreed that training is required and have provided references to training courses in the rationale and impact section of the guideline.
Obesity Group of the British Dietetic Association	Guideline	008	001	We agree with these proposed changes. In particular we agree that assessment of central adiposity in children may help identify those who would benefit most from intervention. However, we also agree that permission from both the child and parent/carer should be sought before discussing clinical findings.	Thank you for your comment.
Obesity Group of the British Dietetic Association	Guideline	009	018	We support the principle of interventions tailored to need. However, we would like to see mental and emotional health and wellbeing added to this list since children may be at risk of exclusion or bullying as a result of their weight, and due to their developmental stage, may be at particular risk of mental and emotional harm.	Thank you for your comment. Based on the feedback received, committee amended recommendation 1.2.28 to include 'mental and emotional health and wellbeing'.
Obesity Group of the British Dietetic Association	Guideline	010	010	We agree with these research questions.	Thank you for your comment.
Obesity Group of the British Dietetic Association	Guideline	019	001	This update represents an opportunity to emphasise training needs for healthcare workers in weight management in adults, children and young people.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge

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					on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
Obesity Group of the British Dietetic Association	Guideline	019	01	Suitable resources need to be in place to allow these recommendations to be put into practice. These include accurate scales, height measures, tapes measures, BMI charts and resources to support intervention decisions.	Thank you for your comment
Obesity Group of the British Dietetic Association	Guideline	019	027	We agree that people who would benefit from interventions are identified opportunistically. However, it is not clear how this guidance will alter that. This relates back to points 1.1.1 and 1.2.1 about using clinical judgement to measure people. Perhaps it should be rephrased as taking every reasonable opportunity and with a goal e.g. that all people on a GP list have an annual weight, waist: height, BMI recorded.	Thank you for your comment. Recommendation 1.2.1 is outside the remit of the current review questions. Recommendation 1.2.1 is also due to be updated as part of a forthcoming update that will examine effectiveness of interventions to identification and increasing uptake of weight management services. For further information, please refer to the scope. Your comment will be taken into consideration when conducting future updates.
Office for Health Improvement and Disparities	Evidence review 1	268	012	Research recommendation – There is evidence and a BME-Child BMI adjust tool developed by a research group at University of London St Georges https://www.sgul.ac.uk/about/our-institutes/population-health/research-themes/health-lifestyle-and-environments/bmi-adjust Has NICE considered this evidence? Is it not sufficient yet to change existing recommendations and thresholds for Child BMI weight	Thank you for your comment. While the papers detailed in the comment address overweight-obesity patterns in children using body mass index (BMI) they are not included in the review because they do not use a prognostic or diagnostic accuracy study design linking overweight/obesity to a condition of interest:

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				categories adjusting for ethnicity, is this because the studies did not explore health risks in relation to BMI? OHID supports the recommendation for further research in this area. Studies shared at consultation stage included: • Body mass index adjustments to increase the validity of body fatness assessment in UK Black African and South Asian children doi:10.1038/ijo.2017.75. Hudda etal 2017 • Reassessing Ethnic Differences in Mean BMI and Changes Between 2007 and 2013 in English Children https://doi.org/10.1002/oby.22091. Hudda etal 2017 • Patterns of childhood body mass index (BMI), overweight and obesity in South Asian and black participants in the English National child measurement programme: effect of applying BMI adjustments standardising for ethnic differences in BMI-body fatness associations 10.1038/ijo.2017.272 Hudda etal 2018 Understanding local ethnic inequalities in childhood BMI through cross-sectional analysis of routinely collected local data https://doi.org/10.1186/s12889-019-7870-2 Murphy etal 2019	Hudda 2017a: This study attempts to create adjustments to BMI by ethnic group using the deuterium dilution method to assess and compare groups. Hudda 2017b: It assesses the BMI of children in the) National Child Measurement Programme (NCMP) using their previously created ethnicity specific adjustments. Hudda 2018: Similar to the above it assesses the BMI of children in the) National Child Measurement Programme (NCMP) using their previously created ethnicity specific adjustments. Murphy 2019: It attempts to assess variation in child BMI across ethnic groupings in Coventry, UK. As highlighted in the rationale and impact section of the guideline document, there was a lack of evidence on boundary values for children and young people from different ethnicities. Due to this the committee were unable to draft specific recommendations for BMI boundary values in children and young people from different ethnicities but did draft a research recommendation to facilitate further research in this field.
Office for Health	Guideline	General	General	Need to consider the resources and time required for HCPs in implementing these recommendations, and	Thank you for your comment. Based on stakeholder feedback, the recommendations have been amended

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Improvement and Disparities				supporting people to measure their waist/height, calculating the waist-to-height ratio and interpreting it. The guideline encourages people/parents to take responsibility for this but also recommends a discussion with the HCP on next steps once it is determined that there is need for intervention.	to further explain how waist-to-height ratio should be calculated. The committee did take these factors into consideration but highlighted those costs associated with resources and training are justified by health improvement among people with overweight and obesity in the long term.
Office for Health Improvement and Disparities	Guideline	General	General	What is the driver/evidence for why the guideline prioritises HCPs encouraging self-measurement at recommendation 1.1.2? Whilst HCPs and AHPs consultations need to prioritise and be patient focussed is it not more pertinent for the recommendations on measurement to come first i.e. recommendations 1.1.3-1.1.5?	Thank you for your comment. Evidence on self-measurement was not evaluated as part of this review question however based on their experience and expertise, the committee highlighted a number of benefits associated with self-measurement. This included the fact that self- measurement using waist to height ratio (WHtR) can be done during remote appointments and also allows a person to keep a personal record. The committee also noted that a benefit of this is that it may reduce the stigma associated with a healthcare professional doing measurements. For further information on the committee discussions please see section 1.1.11 in evidence review A and B. Additionally, the order of the recommendations does not reflect which recommendations should be prioritised in practice.
Office for Health	Guideline	008-009	028	1.2.4 – whilst we agree that the inclusion of BMI SD for overweight, obesity and severe obesity is a useful addition for clinical interpretation please note that the	Thank you for your comment. This guideline has utilised the clinical definitions of overweight or obesity for children and young people as defined in the

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Improvement and Disparities				BMI SD for these weight categories are not referred to on the RCPCH growth charts only the BMI centile's of 91st, 98th and 99.6th are. Child BMI SD is a technical and complex term so we would recommend for a definition to be included in the Glossary guidance and ensure that it includes BMI Z-score is an interchangeable term to avoid confusion, although BMI SD is the UK term, BMI Z-score is being used more widely now and used in the explanation about why the changes to the recommendations have been made. It is also included in the National Child Measurement Programme data collection IT System. A table like the one included in the NCMP Operational Guidance 2021 p.35 may be useful to refer to demonstrate how the weight category, BMI SD and BMI centile is explained in the context of the NCMP. HCP's will need definitions to help them interpret the guidelines when working with CYP and parents. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1016653/National_Child_Measurement_Programme_operational_guidance_2021.pdf	RCPCH BMI growth charts which are linked in recommendation 1.2.21. The committee are also aware the RCPCH growth charts display BMI SDs especially for those in the clinical and severe obesity category. Based on the feedback received, the rationale and impact section of the guideline has been amended to define BMI SD and have also stated that term is interchangeable with BMI z-score. The rationale has also been amended to provide reference to resources such as the NCMP operational guidance that can be used by professionals involved in measuring children and young people to understand how the clinical definitions of BMI link to BMI centiles and SDs.
Office for Health Improvement and Disparities	Guideline	006	018	1.1.10 discussing need – at which level should the HCP intervene? At 'increased' or 'high' level of adiposity – or is it at the HCPs discretion? Currently it is unclear.	Thank you for your comment. The committee agreed that health risks as well as BMI are important to take into consideration when discussing and agreeing level of intervention. Based on stakeholder feedback, the committee amended recommendation 1.2.15 to state that level

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					of intervention should be discussed and agreed with adults who are living with overweight or obesity or have increased health risk based on waist-to-height ratio.
Office for Health Improvement and Disparities	Guideline	006	025	1.1.11 - should this recommendation come earlier – at the point before being measured? Suggest inserting an additional recommendation prior to measurements recommendation 1.1	Thank you for your comment. The committee agree that permission should be sought at the point of taking measurements. It should be noted that further updates have been planned which will be examining the effectiveness of identification of overweight and obesity. This will result in the development of further recommendations to support recommendations on assessing overweight and obesity. Your comment will be considered during the development of future questions on identification. For further information on the updates planned for weight management guidelines, please refer to the scope.
Office for Health Improvement and Disparities	Guideline	007	005	1.1.13 – suggest the HCP finds out/understands what weight management services, and other services are available in the local area to support referrals and signposting of patients to services	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider how weight

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					should be discussed, the issues around weight stigma and using sensitive language. It should also be noted that further work has been planned for the guideline, which includes a review into increasing uptake of weight management services in adults, children and young people. For further information please refer to the scope.
Office for Health Improvement and Disparities	Guideline	007	012	1.1.14 – NICE may want to consider defining what is meant by a 'higher level of intervention' or is the reference to other guidance felt satisfactory?	Thank you for your comment. The committee highlighted that higher level interventions were well defined in CG189 and added a cross reference to those relevant sections.
Office for Health Improvement and Disparities	Guideline	008	020	1.2.3 – Is there evidence to support the inclusion of an upper BMI centile/BMI SD when waist to height ratio shouldn't be done like in adults with a BMI>35kg/m^2	Thank you for your comment. Unlike the adult's data, limited evidence was identified to ascertain ranges for waist-to-height-ratio (WHtR) in children and young people (CYP). As highlighted in section 1.1.11 in evidence review B, the committee did take evidence identified in adults into consideration and drafted a recommendation to state that WHtR can be considered in children and young people. It is understood that in adults with BMI equal to or greater than 35 kg/m^2, waist-to height ratio is usually high, therefore, the measurement adds very little to the prediction of health risks.

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					The committee noted that a similar statement cannot be made in children and young people due to the general lack of evidence in this age group. The committee have drafted a research recommendation to further explore the accuracy and suitability of these measures in assessing health risk associated with overweight and obesity. The committee made a note that a combination of methods of measurement can also be explored in studies. This can help build knowledge of the accuracy of using measures such as BMI and WHtR together and to identify the optimal boundary values. For further information please see evidence review B, appendix L.
Office for Health Improvement and Disparities	Guideline	009	009	1.2.5 – whilst the evidence base might now support the introduction of WHtR as a measure of central adiposity and increased risk to health in CYP, this recommendation will be a challenging change in practice because there are no national tools or practical guidance to support HCP's and parents to measure their child's waist accurately. OHID is aware of the Ashwell Shape Charts and Calculators. Has NICE and the committee considered how accessible these types of tools are? Has or will NICE consider as part of its broader review of the obesity guidelines what recommendations and resource (there will be cost implications) might be needed to make such tools more accessible such as re-developing existing NHS	Thank you for your comment. The committee agreed that there are resources available that can help HCPs and parents to measure their child's waist accurately and interpret the results. The committee have now referenced the NHS Healthy weight calculator in recommendation 1.2.3 as a resource that provides information on how to measure waist when self- measuring, as well as a number of other resources to define overweight and obesity in children and young people in recommendation 1.2.21. They have also amended the rationale and impact section to include these education resources and tools. It should also be noted that the resource

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				web-pages; digital tools and practice guidance for instance how to take an accurate waist and height measurement in a child or young person. Also, will NICE consider what evidence there is to support how such tools are utilised.	impact statement will also be published along the guideline.
Office for Health Improvement and Disparities	Guideline	009	018	1.2.7– should this be 'and/or'. Consider tailored interventions for children with a BMI at or above the 91st centile or waist-to-height ratio of 0.5 or more. i.e. the combination of BMI >91st with WtHR of 0.5 would demonstrate the highest risk for children falling in the overweight category	Thank you for your comment. The committee have amended recommendation 1.2.28 to highlight that children and young people who are living with overweight or obesity or have increased health risk based on waist-to-height ratio can be considered for tailored intervention.
Office for Health Improvement and Disparities	Guideline (impact in practice)	019	006	How the recommendations might affect practice - please note that none of the DHSC and HEE training on the identification and assessment of child overweight and obesity includes waist to height ratio. There will be a cost to updating all relevant training modules and consideration will be required in terms of how to support weight management commissioning and practice with guidance. Please note the European Childhood Obesity Group (ECOG) training resource 'Childhood obesity from diagnosis to treatment' is **not** fully in line with the proposed updated recommendations in module 1, waist to height is referred to as a measure of abdominal fat but the key points for practice still advise BMI centile, refer to skin-fold measures and the need to adapt for ethnicity which NICE evidence concludes that it should remain universal for all children	Thank for your comments. The committee acknowledge that the new recommendations may not be in line with existing training however, there is scope for these training courses to be updated based on the new guidance. The committee agreed that the costs associated with updating training course are likely to be small. Given that the annual cost of obesity amounted to be around £6.1 billion to the NHS and £27 billion to the wider economy, as calculated by the Public Health England, the additional training costs are likely to be outweighed by long-term health benefits. The rationale and impact section has been amended to justify the additional training costs involved.

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				regardless of sex and ethnicity. The assumption that the training programmes mentioned in both the draft guidance and the Evidence review are in line with the new recommendations is inaccurate.	
Royal College of General Practitioners	Guideline	General	General	Overall the guidance appears very appropriate in encouraging a more proactive approach to healthy weight and activity. We should comment that the workforce is under considerable pressure (both numbers of clinicians especially in primary care; and clinical back log of work – linked to the covid19 pandemic and back log of work elsewhere in the NHS). The time taken to consult patients in the current NHS system is not conducive to appropriate timely interventions and this should be considered. Equally it is important that resources are available to be able to support any onward referrals in a timely fashion.	Thank you for your comment. The committee acknowledged that pressures on the workforce, but they also noted that these recommendations are to be implemented over time and have been developed to be applicable to the post pandemic period as well. The committee further highlighted that obesity-related conditions worsen the effect of COVID-19, which has had a massive impact on the service and an impact that continues to take effect. Based on this understanding, this committee agreed that action needs to be taken. The committee also agreed that resources need to be available to support people. While availability of resources are local implementation issues, the committee hope that this update and subsequent updates of the weight management guideline bring out positive changes in the system.
Royal College of General Practitioners	Guideline	004	010	We note the suggestion of encouraging people to measure their own waist measurement and wondered if the panel felt there was sufficient evidence for accuracy in this area (though agree with the stigma and at times difficulty in a health care professional undertaking the measurement). Similarly, at a stage in healthcare where more on line / video and telephone	Thank you for your comment. Evidence was not identified which examined the accuracy of waist or weight measurement when conducted by individuals however, as WHtR is a simple measure with clear message of 'keep your waist less than half your height', the committee felt it was important to encourage people to self measure using waist-to-

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				consultations are part of routine practice – do the guideline group feel that home reading of weight is an adequate substitute for clinic readings?	height ratio as this can help trigger people to seek advice. The committee agreed that there may be errors involved with taking measurements. However, self-measurement and self-reporting of measurements is becoming standard practice due to consultations taking place remotely. For example, blood pressure, weight and blood sugar levels are now being reported by people. Based on stakeholder feedback received, the committee further amended the recommendations to further explain how the waist should be measured and how waist-to-height ratio should be calculated.
Royal College of General Practitioners	Guideline	005	020	It would be hoped that NICE can liaise to ensure that GP computer systems are able to use the most up to date height / weight information and ideally that the coding is changed automatically linked to ethnic group	Thank you for your comment. The committee noted that GP recording systems would require updating particularly when it comes to waist-to-height ratio as currently there is no space dedicated to recording this measurement. Based on your feedback, the committee also agreed that update of GP systems in relation to BMI would be useful and hope that the introduction of these new recommendations may encourage the development of more efficient recording systems. NICE will liaise with system partners on this issue.
Royal College of General Practitioners	Guideline	005	023	It would be hoped that NICE can liaise and facilitate use of the height / weight charting in children and	Thank you for your response. Currently, work has not been planned on enabling automatic calculations using height/weight in children and young people

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				young people to enable automatic calculations of the degree of obesity relating to different ages.	however, NICE will liaise with system partners on this issue.
Royal College of General Practitioners	Guideline	006	007	The phrase of possible protective effect of adiposity is vague and unsure how helpful this would be to clinicians. It would be useful to link this to a functional table on this as to how strong the protective effect and in which conditions in those over the age of 65 years. Similar to the comment in page 6 line 28 onwards.	Thank you for your comment. The committee were not aware of any existing functional tables on protective effects and as the focus of this review was on accuracy of anthropometric measures, development of a table would be outside the remit of this update. Limited evidence was identified for older people and the committee drew on their knowledge of the wider evidence base when drafting recommendation 1.2.10. The committee were aware of studies (which were not evaluated as part of this update) which indicate that the risk of all-cause mortality is lowest in people aged 65 and over with BMIs between 27 and 28 kg/m^2 which is formally categorised as 'overweight'. This is highlighted in section 1.1.11 in evidence review A, however, based on stakeholder feedback, the rationale and impact section of the guideline has been amended to clarify that a protective effect of being overweight may be that risk of all-cause mortality may be reduced.
Royal College of Nursing	General	General	General	We do not have any comments on this consultation. Many thanks for the opportunity to contribute.	Thank you for your comment.
Royal College of Paediatrics	General	General	General	The amalgamation of a number of obesity related guidance into one guideline is welcome	Thank you for your comment.

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and Child Health					
Royal College of Paediatrics and Child Health	General	General	General	The additional seven questions proposed are important additional questions.	Thank you for your comment.
Royal College of Paediatrics and Child Health	General	General	General	An important question for young people regarding population level interventions for obesity in health, educational and local authority settings is: Is the publication of calorific and other nutritional information on menus effective in obesity prevention or whether it leads to additional harms (for example for contributes to the development or maintenance of eating disorders). This is important as health, education and local authority settings providing catering for young people need evidence-based guidance on whether to publish calorie content of meals on menus.	Thank you for your comment. The focus of this update was on identifying and assessing overweight and obesity in adults, children and young people. Further updates are planned for this guideline and are highlighted in the scope. However, it should be noted that currently, no reviews have been planned that evaluate the effectiveness of publishing calorific and other nutritional information. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Paediatrics and Child Health	General	General	General	A training need to make sure that the waist: height ratio is done correctly and that tape measures used are suitable for bariatric patients and paediatric patients	Thank you for your comment. The committee noted that recommendation 1.2.2 and 1.2.5 specifically limit waist-to-height ratio to adults with BMI less than 35 kg/m^2. Keeping this in mind, the committee stated that you would not conduct waist-to-height ratio in bariatric patients as their BMI is likely to be above 35 kg/m^2. The committee also highlighted that waist measurements are conducted in practice, therefore,

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					committee stated suitable tape measures should be available.
Royal College of Paediatrics and Child Health	Guideline	General	General	The reviewers were happy with this draft guideline.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Guideline	008	004	We are concerned that children and young people do not generally go for consultations about conditions such as Type 2 Diabetes or cardiovascular disease. We do not believe it is appropriate.	Thank you for your comment. Forthcoming updates of the guideline have been planned which will examine effectiveness of interventions for identification and increasing uptake of weight management services. For further information, please refer to the scope. Your comment will be taken into consideration when conducting future updates.
Royal College of Paediatrics and Child Health	Guideline	009	002	We believe it would be helpful to clarify this refers to waist/height ratio.	Thank you for your comment. This has been clarified in recommendation 1.2.25.
Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the United Kingdom. Its membership based in England represents 51% of its UK membership. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.	Thank you for your comment.

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				The College welcomes this Guideline on Obesity: identification and Classification of overweight and obesity. Obesity is prevalent across the UK and is a major cause of significant morbidity and mortality in the general population especially where there are health inequalities and specific protected characteristics.	
Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The guideline is a good refinement of the previous guideline advice with clearly stated reasons for the update.	Thank you for your comment.
Royal College of Physicians and Surgeons of Glasgow	Guideline	004	009	We consider the weight to height ratio is easier for many patients to understand than BMI. It has an easy to remember target. This is a useful measure to use and communicate to the general public (with caveats below). There appears an evidence base.	Thank you for your comment.
Royal College of Physicians and Surgeons of Glasgow	Guideline	006	004	There are pitfalls in relying on BMI alone in certain groups. There needs to be a paragraph on how apparent height (for instance) can be reduced. In the aging population by shrinkage of intervertebral discs. Development of kyphosis. Development of osteoporosis and/or vertebral collapse.	Thank you for your comment. The committee agreed that shrinkage of intervertebral discs, development of kyphosis and osteoporosis are important factors to take into account when conducting measurements. As part of recommendation 1.2.10, the committee did state that functional capacity should be taken into consideration when interpreting BMI in people aged 65 and over. The committee further explained that functional capacity can be reduced due to age-related spinal disorders. The rationale and impact section of the guideline has been amended to clarify this further.

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				The presence of diseases of hips, knees and ankles promoting flexion deformities so height is not accurately measured (some CCGs have used BMI as a threshold for funding surgical procedures eg Knee arthroplasty without considering fixed flexion deformities of the knee itself).	Additionally, the rationale and impact section does include information on how measurements may need to be modified (for example using sitting hight instead of overall height) in people with physical disabilities in whom height cannot be measured accurately. Furthermore, limited evidence was identified in the older population. In order to facilitate further research older people were included as an important subgroup in the research recommendation (see appendix L in evidence review A for further information).
Royal College of Physicians and Surgeons of Glasgow	Guideline	006	010	With respect to waist to height ratio the potential difficulties of measurement of this needs to be discussed. Height measurement can be distorted as discusses in 3 above. In addition, waist can also be falsely exaggerated by the development of a kyphosis.	Thank you for your comment. The committee agreed that measurements may be distorted due to the presence of age-related spinal disorders. Section 1.1.11 in the evidence review A has been amended to further highlight committee discussions on potential difficulties associated with taking measurements in the older population. Additionally, due to the limited evidence identified in the older population the committee were unable to draft further recommendations for this age group. However, the committee did consider older people as an important subgroup. Based on this discussion, appendix L in evidence review A has been amended to include older people as a subgroup.
Royal College of Physicians	Guideline	006	024	While clinicians have to talk about weight issues with sensitivity, the guideline does not make recommendations as to how this should be done in	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the

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and Surgeons of Glasgow				practice. Our reviewer was concerned about the recommendation that we should ask the patient's permission before talking about their weight. This appears to give the patient a veto on discussing this. For many conditions (eg type 2 diabetes and non-alcoholic fatty liver disease) this is the most important part of their management. If we allow patients a "veto", we are not able to offer them the optimum health advice. This may not have been intended by the authors but it was how they were perceived. We completely agree that advice needs to be given sensitively.	resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
Royal College of Physicians and Surgeons of Glasgow	Guideline	010	008	We welcome the research recommendations on the cognitive effects of these treatments and also their impact on frail older patients, since both these areas are relatively lacking in research investment.	Thank you for your comment.
Sig-Nurture Ltd	Evidence review	general	general	Clearly a vast amount of effort has gone into the evidence review, as is proper. However, the 2 documents are dense and difficult to navigate, and lack any form of synthesis. It is difficult to see the wood for the trees. It would be most helpful to provide an executive summary or abstract of the findings in text form, rather than merely tables.	Thank you for your comment. We agree that the reports contain a lot of data and information, with this in mind there are several places in the guideline documents that readers can go to see summaries of the evidence and understand the committee's decision making. Key places to look are the rationale sections linked to the recommendations in the guideline and the committee's discussion and interpretation of the evidence in the evidence reviews.

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Sig-Nurture Ltd	Guideline	General	General	As a researcher in this field for many years, I welcome the updated guideline and its recommendation to use waist-to-height ratio as an indicator of health risks associated with central adiposity. Using WHtR in clinical practice and community settings should enable the better identification of adults and children whose health may be impacted by obesity, including those who are in the upper range of normal weight. As shown in the substantial evidence review, this recommendation is based on a large number of studies in different populations and ethnicities. The applicability of the same WHtR boundary values for people of different age, sex and ethnicity is a huge advantage in communicating to the public and encouraging self-monitoring. Routine measurement of children's waist circumference via the child measurement programme and large-scale surveys would allow monitoring of trends and provide data on WHtR for further analysis to answer research gaps.	Thank you for your comment. The child measurement programme is outside the remit of the work carried out by NICE. The Office for Health Improvement and Disparities provide strategic leadership and support for this programme.
Sig-Nurture Ltd	Guideline	general	general	Given that the guideline is about measures and classification of **central adiposity** as well as overweight and obesity (page 5) it would be more consistent if central adiposity were also included in the guideline title and recommendations 1.1 and 1.2. This would also make clear that the emphasis has shifted beyond BMI to assess health risk.	Thank you for your comment. The committee agree that it makes sense to include central adiposity in the title of the guideline as this is understood to be the linking factor to the conditions of interest. The guideline title and subheadings have been edited to reflect this.
Sig-Nurture Ltd	Guideline	General	General	There is scant reference in the Guideline to the evidence review, which underpins the	Thank you for your comment. The guideline document was developed in accordance with the

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				recommendations. It would improve confidence in the recommendations if the protocol and a short summary were described briefly in the guidelines document, *for example* "A combined search was conducted for the adults and children and young people review. A total of 14,299 studies were identified in the search, of which XX met inclusion criteria. There were insufficient prognostic studies covering some ethnicities and so diagnostic studies were added. For most outcomes and populations, WHtR provided equal or better accuracy than other anthropometric measures" etc..	guidance provided by our editorial team. The rationale and impact section provides a short explanation of why the committee made the recommendations. The full details of committee discussions are covered in the evidence review, which are hyperlinked in the guideline document.
Sig-Nurture Ltd	Guideline	004	016	Rec 1.1.2. "You can also direct people to resources such as the NHS BMI healthy weight calculator" .. It seems confusing to direct people to this link given that the paragraph is about waist-to-height ratio and the link is about BMI and waist circumference (the basis for the previous NICE matrix). Given that lines 13-14 explain how to take a waist measurement, this link seems inappropriate and could be deleted.	Thank you for your comment. The committee agreed that the NHS BMI healthy weight calculator does not specifically provide information on waist to height ratio. However, they did consider this as a useful resource for explaining how waist circumference can be measured. The rationale and impact section of the guideline has also been amended to highlight other resources, including tutorials on how the waist should be measured.
Sig-Nurture Ltd	Guideline	010	009	The recommendations for research are very general and merely reiterate the initial scope. It would be more helpful to suggest topics for future research calls and funding, such as "utility of waist-to-height ratio boundary values in assessing current and future health risk"; "prevalence and risks of normal weight central	Thank you for your comment. Research recommendations were drafted to be in line with the original research question to ensure that further research allows future updates of recommendations.

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				obesity" "practicalities of using WHtR in community and clinical settings"	
Sig-Nurture Ltd	Guideline	012	014	"but waist circumference measurements are inaccurate in people with BMI over 35kg/m^{2}" . Rather than being inaccurate, is it not the case that waist measurement in people with this degree of obesity is almost always high and therefore adds little to the prediction of health risk?	Thank you for your comment. Further clarification has been added as to why WHtR may not be suitable in people with BMI over 35 kg/m^{2}.
Sig-Nurture Ltd	Guideline	013	028	"a boundary value of 0.5 to 0.59"…A boundary value is singular, so suggest this should be changed to "a range of 0.5 to 0.59"	Thank you for your comment. This change has been made to the rationale and impact section.
Total Diet & Meal Replacements Europe	Guideline	General	General	Total Diet & Meal Replacements (TDMR) Europe is the European trade body for manufacturers and distributors of total diet replacements (TDRs) and meal replacements (MRPs), which provide weight loss and weight management programmes for the overweight and obese. TDRs, which include very low-calorie diets (VLCDs) and low calorie diets (LCDs), are specifically formulated programmes that are based around formula foods that replace the whole of the daily diet. These formula foods are nutritionally balanced with key vitamins, minerals, high quality protein, essential fats, and fibre, and are designed to replace conventional foods for a period to facilitate optimal weight loss. MRPs are products presented as a replacement for one or more meals of the daily diet. They are used	Thank you for your comment. Total diet and meal replacements were outside the remit of the current update. Further updates of this guideline will examine the effectiveness of total or partial diet replacements, intermittent fasting, plant-based and low carbohydrate diets in achieving and maintaining weight loss in adults living with overweight and obesity. For further information, please refer to the scope.

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				alongside conventional food, as part of an energy restricted diet, to facilitate and maintain weight loss. High quality clinical trials and feasibility studies in primary care and community settings (with health economic analyses of these) have demonstrated that such effective weight loss interventions are feasible, clinically effective and cost-effective. Addressing overweight, obesity, excessive organ fat in non-obese individuals, and specific obesity-related comorbidities requires the construction of multi-layered services, including specialist medical and bariatric surgical units in every major hospital, and specialist GP hubs to deliver diabetes remission and other health benefits of weight loss/reduced organ fat loss. The delivery of these services is challenging for all service levels but there needs to be political engagement. Put it simply, this problem cannot be solved without more ring-fenced funding for specialist services, for specialist GP hubs and for proven public health interventions. Users facing challenges to implementing these guidelines would be helped by cross departmental cooperation within the UK. While some progress has been made in restricting advertising of foods, there may be more work to do. Facilitation of physical activity through serious planning of the built	

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				environment rather than minor tinkering is a long term project. Freedom from EU subsidy and taxation rules could allow subsidization of some foods and heavier taxation of others. Legislation to limit portion size would probably be dismissed as too draconian and politically unpopular. Finally, health care professionals need to be educated on nutrition and diet in relation to health and disease at all levels – undergraduate, postgraduate, and continuing professional development programmes – and while some progress has been made over the last forty years there is still more to do. TDMR Europe supports the proposal to create a single guideline that will fully update and replace NICE's guidelines on: • preventing excess weight gain (NG7) 1 • obesity: identification, assessment and management (CG189) • weight management: lifestyle services for overweight or obese adults (PH53) • weight management: lifestyle services for overweight or obese children and young 19 people (PH47) • BMI: preventing ill health and premature death in Black, Asian and other minority 21 ethnic groups (PH46) • obesity: working with local communities (PH42) • obesity prevention (CG43).	

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				However, TDMR Europe recognises that there may also be disadvantages to merging clinical and public health guidelines, including further delays in the incorporation of newly discovered treatments into clinical guidelines when there may be no indication for an overall review. TDMR Europe recommends that care be taken before making this decision. Pharmacological management of obesity is likely to progress rapidly over the next 5 to 10 years and a case could be made for keeping clinical management separate from public health management. Regarding the updates to the recommendations on *obesity: identification and classification of overweight* that are subject to this specific consultation, TDMR Europe welcomes the wording introduced and particularly the recommendations that we mention in our below comments. Partial updates have merit in facilitating more rapid updating of specific areas of the guidance but keeping track of all updates can be a challenge for busy overworked health care professionals. TDMR Europe looks forward to the opportunity to provide feedback on upcoming consultations to update recommendations on weigh management for overweight and obese adults.	

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Total Diet & Meal Replacements Europe	Guideline	005	005	TDMR Europe welcomes the fact that draft guidelines mention the use of waist-to-height ratio and how to use this parameter in conjunction with BMI thresholds in adults whose BMI is below 35 kg/m², in order to help define central adiposity and help to assess and predict health risks. This is consistent with the latest scientific evidence.	Thank you for your comment.
Total Diet & Meal Replacements Europe	Guideline	005	023	TDMR Europe welcomes the discussion of reclassification of categories and the language around the BMI thresholds in South Asian, Chinese, other Asian, Middle Eastern, Black African or African populations. TDMR Europe supports a 2.5 BMI reduction in each obesity class starting point and the low classification starting at a BMI of 23 for these groups. This provides much needed clarity.	Thank you for your comment.
Total Diet & Meal Replacements Europe	Guideline	006	028	TDMR Europe welcomes the fact that obesity co-morbidities – type 2 diabetes, cardiovascular disease, 1 hypertension, dyslipidaemia, certain cancers, respiratory conditions, 2 musculoskeletal conditions and other metabolic conditions such as non-3 alcoholic fatty liver disease – are now clearly listed in the guidance, which will provide better clarity.	Thank you for your comment.
Total Diet & Meal Replacements Europe	Guideline	007	012	TDMR Europe also welcomes the mention in the guidelines of the need to offer a higher level of intervention to obese individuals when one co-morbidity is present.	Thank you for your comment.

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University of London	Guideline	General	General	I was delighted to see that the draft guidelines now include the waist to height ratio (WHtR) as a measure of obesity, alongside the traditional BMI, since peer reviewed research suggests that the WHtR is an important measure of mortality and morbidity risk. For example, the following paper demonstrates that the WHtR was a better predictor of mortality risk than BMI. The number of Years of Life Lost (YLL) for different values of WHtR was also quantified. This was done separately for both sexes and for three representative ages. The paper is: Ashwell, M., Mayhew, L., Richardson, J. and Rickayzen, B. (2014). Waist-to-Height Ratio Is More Predictive of Years of Life Lost than Body Mass Index. *PLoS ONE*, *9*(9). *doi:*10.1371/journal.pone.0103483.	Thank you for your comment and for alerting us to this paper. This paper would not be included in the review in adults as it is not a prognostic accuracy study and in does not provide data stratified by ethnic background.
University of London	Guideline	006	010	The cut off values of 0.5 and 0.6 shown in lines 10 to 23 of section 1.1.10 accord well with the cut off values which are suggested in: Ashwell, M., Mayhew, L., Richardson, J. and Rickayzen, B. (2014). Waist-to-Height Ratio Is More Predictive of Years of Life Lost than Body Mass Index. *PLoS ONE*, *9*(9). *doi:*10.1371/journal.pone.0103483.	Thank you for highlighting this study. The Ashwell 2014 study was not included in the review in adults because it is does present prognostic accuracy data. However, the committee agree it supports the recommendations relating to waist-to-height ratio made in this guideline.

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University of Oxford	Guidance	006	018	Cardiovascular risk is prioritised with waist-to-height ratio. What about the increased risk of musculoskeletal problems, cancer, or asthma? The distribution of adiposity is less important here. Was the risk of these diseases considered in this recommendation? What is the evidence that waist-to-height is a materially better measure of the overall morbidity associated with excess weight than BMI?	Thank you for your comment. Recommendation 1.2.11 provides examples of conditions for which evidence was identified. During the review protocol stage, type 2 diabetes, cardiovascular disease, cancer, dyslipidaemia, hypertension and all-cause mortality were identified as conditions of interest. However, evidence was not identified for cancer, therefore the committee could not draft recommendations to cover this condition. Additionally, the committee accepted that this review could not cover all the conditions linked to overweight and obesity, but they did take these into consideration when drafting recommendations. Recommendation 1.2.14 states that healthcare professionals should give adults information about the severity of their obesity and central obesity and the impact this have on their risk of developing other long-term conditions such as type 2 diabetes, cardiovascular disease, hypertension, certain cancers, respiratory conditions, musculoskeletal conditions and other metabolic conditions. For further information about committee discussion, please refer to section 1.1.11 in evidence review A.
University of Oxford	Guidance	006	020	We are unconvinced the message 'Keep your waist to less than half of your height' can be easily implemented. Most people know their height in feet	Thank you for your feedback. Based on stakeholder feedback, the committee retained the public health message highlighted in the recommendation but did

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				and inches and weight in stones and pounds. Five foot seven inches is difficult to halve. What is the evidence this is better understood and applied by patients? This is important as patients will be encouraged to do this themselves.	agree that further clarification needs to be added about how waist-to-height ratio should be calculated. Recommendations have been amended to provide further information on how waist-to-height ratio should be calculated and examples of calculations have also been provided.
University of Oxford	Guidance	006	028	Is the addition of another metric (waist-to-height ratio) in addition to BMI, necessary to adequately communicate the risk of excess weight to patients? Calculating and communicating two metrics would leave less time for discussion about management of obesity, arguably the more important part of the consultation. This is particularly important in the context of a 10-minute GP consultation. Is this not adding more friction to the system?	Thank you for your comment. The committee took your comment into consideration and acknowledged the pressures within the system. In their clinical experience, discussions about weight and weight management can require multiple appointments. For example, in people living with more severe obesity or complex obesity may require multiple appointments. One of the benefits of waist-to-height ratio is that the measurements can be conducted by the individual, and this can even take place over remote appointments.
University of Oxford	Guidance	015	020	The (small) cost of implementing the waist-to-height ratio was justified because of better health outcomes. What is the evidence that knowledge of waist-to-height ratio, in addition to BMI alone, resulted in better health outcomes?	Thank you for your comment. During committee discussions, it was highlighted accumulation of excess fat in the abdominal area is linked to conditions such as type 2 diabetes and cardiovascular disease and that BMI alone is not an estimate of this central adiposity. There was a lack of evidence for the combined use of measures and only 2 studies were identified that

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					looked at the combined use of BMI with waist measurements. While there was a lack of evidence, the committee noted that it was important for central adiposity to be considered alongside overweight and obesity. The committee consensus was that while the main measure for overweight and obesity is BMI, the added classification for central adiposity would need to be determined through waist-to-height ratio. It should be noted that this measure replaces waist circumference, which was previously recommended in CG189. Please see section 1.1.11 in evidence review A for further information on the evidence and committee discussions.
University of Oxford	Guidance	015	027	Waist-to-height ratio is described as having minimal cost impact as tape measures are routinely available in NHS clinical settings. What about remote consultations? A large number of patients, especially more vulnerable groups, will not have access to a suitable tape measure and an HCA/ nurse appointment or a loan system would be required to measure this. Was this considered in the guidance?	Thank you for your comment. The committee agreed that tape measures are cheap and widely available, and there are many alternative options available as well such as the string test which involves an easily accessible string to be used to measure height and then folded in half to measure waist. Further information on the string test has also been added to section 1.1.11 in the evidence reviews. There might be an increase in the number of HCA/nurse appointments for measuring people from

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					vulnerable groups. However, the committee agreed that this is generally in line with the current practice when people rely on BMI measurement alone.
University of Wolverhampton	Answer to questions as requested above.	General	General	• Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Use of sensitive language will have a big impact on patient motivation, and trust in clinicians. Preferred terms for people living with obesity are not in general use, and often the terms used can feel blaming, shaming or belittling. There is an opportunity here to get this right, however practitioners may need more tools than are provided her to help them judge what is meant by a 'sensitive manner'. We appreciate that implementing the revised calculation for waist to height ratio WHT·5R=WC/Height0.5 is not as straight forward to self-administer. However the disadvantage of shorter people being unduly stressed by incorrectly failing NICE's recommendation (WTHR >0.5), whilst taller individuals might be lulled into a false sense of security could be problematic. We would suggest a simple online calculator could be launched to assist with this, such as the existing online BMI calculators.	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language. In terms of revised calculation for waist-to-height ratio, other stakeholder comments were identified which highlighted papers which examined the revised WHT.5R calculation. These papers were reviewed but were not included in the evidence review as these did not match our review protocol (for further information, please see appendix A in evidence review A for the full review protocol). Additionally, the committee did take issues raised about waist- to -height ratio into consideration, particularly the issue of using the measure in shorter people however, all studies identified in the review on

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				• Would implementation of any of the draft recommendations have significant cost implications? We cannot comment on this. • What would help users overcome any challenges? (For example, existing practical resources or national initiatives.) To overcome the challenge of discussing weight sensitively, we can look to existing work that has been done on preferred terms for other health conditions, and ask the patients individually. Person first language is typically preferred. There is potential for training on the impact of weight-based stigma could be offered to clinicians. • This partial update on 'identification and classification of overweight and obesity' relates to questions 1.1 and 1.2 within the scope of Weight management: preventing, assessing and managing overweight and obesity (update). This is considering 7 further questions and will eventually bring together a number of existing NICE guidelines into a single guideline. Please could you comment on whether it would useful to have further partial updates relating to some of those questions, or you	waist-to-height ratio, used the standard calculation of waist circumference divided by height. Based on these factors, recommendations were not changed to incorporate the revised calculation. However, the committee agreed more research was important to confirm the measure's accuracy and linking it to relevant prognostic outcomes. In doing so it may become clear what a suitable boundary value would be. In addition, it is important to utilise this measure on people with a range of family backgrounds to confirm it is valid in those populations. As such it has been included in the research recommendation linked to evidence review A and referenced in the committee discussion. The committee also noted that there aren't existing calculators for waist-to-height ratio however, recommendations were amended to provide further clarification on how the waist should be measured as well as how waist-to-height ratio can be calculated. Furthermore, thank you for sharing your thought and concerns about NICE consultations. It is anticipated that another discreet consultation will take place which look focus on the referral criteria for bariatric surgery, followed by the final consultation of the full amalgamated guideline.

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				would prefer to wait and see the entire weight management pathway in one guideline. Our stakeholder team would prefer to the entire weight management pathway in one guideline as it makes sense to appraise it altogether.	
University of Wolverhampton	Classifying overweight	005	023	1.1.7 to 1.1.9 give exceptions and cautions in classification. However, no mention is made of people with rare genetic or epigenetic causes of obesity e.g. Prader-Willi syndrome [See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6226269/]. Also use of BMI is more challenging in people with concurrent physical disabilities e.g. scoliosis, those who use a moulded wheelchair for example which may usefully be mentioned in the section on page 19, 12.	Thank you for your comment. The committee noted that the recommendations 1.2.7 to 1.2.9 would be applicable to people with rare genetic or epigenetic causes of obesity (Prader-Willi syndrome) as BMI would be measured and interpreted in the same manner. Additionally, the committee did agree that use of BMI is more challenging in people with concurrent physical disabilities. The rationale and impact section as well as section 1.1.11 in evidence review A and B have been amended to highlight this.
University of Wolverhampton	Evidence G	007	032	"other Asian" group should be clarified to list which ethnicities.	Thank you for your comment. The committee used the UK census definition in the protocol. This definition does not list nationalities that sit within the "Any other Asian background" ethnic group. The specific ethnic backgrounds covered by the included studies were already listed in "1.1.4.1 Included studies" in the review in the adult population. Studies exploring other Asian population

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					included Thai, South Korean and Japanese populations. The 'other Asian population' has also been clarified in the review covering children and young people (please see evidence review B). The rationale and impact section has also been amended to include examples of 'other Asian' family backgrounds.
University of Wolverhampton	Evidence G	329	General	Model used for the generation of the forest plots need to be indicated (fixed effect or Random effects), also using only two studies to produce evidence is not the best practice.	Thank you for your comment. FE model or RE model is stated in the forest plots. All were checked to confirm that a random effects model was utilised when I^2 was greater than 50%. Forest plots where a fixed effects model has been applied instead of a random effects model have now been amended. Additionally, the number of studies in any given meta-analysis is determined by the number of included studies reporting the outcome. If only two studies report a given outcome, then the meta-analysis will reflect that.
University of Wolverhampton	Guideline	004	010	Relative to 1.1.2 - Mention how frequently to check weight to height ratio – we suggest annually. Prompt to record the data somewhere memorable. Recording is useful but we need to encourage patients to engage with and use the data they capture. When would they seek help? Offer further advice around	Thank you for your feedback. Further updates of this guideline have been planned which will examine identification of overweight and obesity and increasing uptake of weight management services (please refer to scope for further information). Your feedback on frequency of measurement and

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				what to do with the data to encourage and motivate patients to take agency with this.	recording of data will be considered during forthcoming updates of this guidance.
University of Wolverhampton	Guideline	004	010	Rec 1.1.2 – May it be useful to outline more explicitly the waist to height ratio calculation, alongside explaining where to measure waist circumference to minimise any ambiguity? It is mentioned, but further down in the guideline (page 14, lines 6-7)	Thank you for your comment. Based on stakeholder feedback, the recommendations have been amended to provide further information on how waist-to-height ratio should be calculated and examples of calculations has also been provided. Additionally, the rationale and impact section of the guideline has been amended to highlight other resources that provide further guidance on how to measure waist circumference.
University of Wolverhampton	Guideline	004	010	Regarding the use of waist to height ratio to assess obesity, the catalyst for this decision appears to come from research by Ashwell et al.[1] who suggests that the waist-to-height ratio (WHTR) is the strongest predictor of cardio-metabolic risk (CMR) in adults. However, Nevill et al.[2] recently demonstrate that waist circumference (WC) increases both theoretically[3] and empirically[2] in proportion to height raised to the power 0.5. Clearly, unadjusted WC will penalize taller subjects (taller people will have, on average, greater WC but not necessarily be at greater health or cardio-metabolic risk). In contrast, WHTR will penalize shorter individuals (the correlation between WHTR and height is negative, i.e., height over scales WC). The only WC-by-height ratio that will not penalize taller or shorter individuals (i.e., it removes the effect of height from WC completely) is the new WHT·5R=WC/Height$^{0.5}$, see Nevill et al.[2], i.e., it correctly scales WC for differences in height. Nevill	Thank you for your comment. References provided in the comment were reviewed. Nevill 2017 and Nevill 2022 were excluded on the following basis: Nevill 2017: This is a diagnostic accuracy study. It is not included in evidence review A because it does not stratify its accuracy results by ethnic background and that's a crucial aspect of this review. In addition, it utilises cardiometabolic risk which is a precursor to relevant outcome conditions listed in the protocol such as cardiovascular disease (CVD) and type 2 diabetes. Nevill 2022: This paper uses cross-sectional data to compare the strength of the associations between the four anthropometric measures and cardiometabolic risk factors. 90% of participants of white ethnicity. It is not included in the review

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				and co-workers[4] recently made this point using a stratified random sample of 53390 participants from private households in England obtained from the Health Survey for England (HSE) 2008-2018.[4] Table 1 (available at: https://www.dropbox.com/s/a5hnshxtimlqwmi/Letter%20to%20the%20editor%20Lancet%20%20v4.docx?dl=0) clearly shows that adopting the cut-off point of WHTR=0.5 will unfairly penalize shorter people. The percentage of people whose WHTR is ≥.5 increases systematically with shorter people, irrespective of age or sex — see bold figures in Table 1. Chi-square tests of independence and for linear trend confirmed that by adopting the cut-off point of WHTR=0.5, shorter individuals will be over penalized and taller people with be under penalizes (in all age-by-sex sub-tables, P<0.001). Based on these observations, shorter people could become unduly stressed by incorrectly failing NICE's recommendation (WTHR >0.5), whilst taller individuals might be lulled into a false sense of security. Cut-off points using the waist "independent-of-height" ratio WC/Height$^{0.5}$ were found to over-come this anomaly. 1 Ashwell M, Gunn P, Gibson S. Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult cardiometabolic risk factors: systematic	because the review in adults did not look for cross-sectional evidence in a white population. Also, it utilises cardiometabolic risk which is a precursor to relevant outcome conditions listed in the protocol such as cardiovascular disease (CVD) and type 2 diabetes. Additionally, the committee did take issues raised about waist- to- height ratio into consideration, particularly the issue of using the measure in shorter people, however studies included in the review that explored the accuracy of waist-to-height ratio calculated the measure using the standard formula of waist circumference divided by height. Due to the lack of evidence for the WHT·5R, this was not included into the recommendation. However, the committee noted that it would be useful to further explore WHT·5R as part of the research recommendation. Section 1.1.11 in evidence review A has been amended to discuss WHT·5R further. Please see below reason for exclusion of the other references provided in the comment: Ashwell 2012: this is a systematic review was not included, but the included studies were checked for inclusion. This has now been highlighted in appendix K of evidence review A.

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				review and meta-analysis. Obes Rev. 2012;13(3):275-86. 2 Nevill AM, Duncan MJ, Lahart IM, Sandercock GR. Scaling waist girth for differences in body size reveals a new improved index associated with cardiometabolic risk. Scand J Med Sci Sports. 2017;27(11):1470-6. 3 Burton R. Waist circumference as an indicator of adiposity and the relevance of body height. Med Hypoth. 2010;75(1):115-9. 4. Nevill AM, Duncan MJ, and Myers T.(in press) BMI is dead; long live waist-circumference indices: But which index should we choose to predict cardio-metabolic risk? *Nut Metab Cardiovasc Dis.*	Burton 2010: this is a study attempting to link waist circumference and height to adiposity and how this should be calculated in adults and children. This did not match our review protocol.
University of Wolverhampton	Guideline	005	009	"1 Measurements for assessing health risks in adults" needs to clarify whether "adults" includes "older adults". For example, those aged >70 years may have different BMI cut-off points for weight management. Thus, in the Guideline, there may be age defined for a certain year.	Thank you for your comment. Adults are defined as individuals aged 18 years and over. Evidence was not identified that suggested that different BMI cut-off points that should be used in older people. However, committee did note that interpretation of BMI is different in older adults. Based on this understanding, the committee drafted recommendation 1.2.10 to highlight that BMI should be interpreted with caution in people aged 65 and over.
University of Wolverhampton	Guideline	005	010	Bioimpedance needs to be defined	Thank you for your comment. Bioimpedance was outside the remit of the review questions, however this will be considered during the amalgamation process which will bring together eight different guidelines. For further information, please refer to scope.

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University of Wolverhampton	Guideline	005	023	Rec 1.1.7 – it would be better to separate the groups "Chinese, other Asian" group from "South Asian, Middle Eastern, Black African or African-Caribbean" in body weight management since their body shapes are different and the cut-off points for obesity associated with health effects are different. For example, we have recently examined a cohort of Chinese aged >=60 years for baseline health survey and have them followed up for 10 years in China using a UK standard method of interview, and found that the BMI-Asian/Hong-Kong cut-off points (<20, 20--<26, 23-<26, ≥26 kg/m2) is better to predict incidence of diabetes than the BMI-China cut-off points (<18.5, 18.5-<24, 24-<28, ≥28 kg/m2), and much better than the BMI-WHO cut-off points (<18.5, 18.5-<24.9, 24.9-<29.9, ≥30 kg/m2) (https://pubmed.ncbi.nlm.nih.gov/35487506/).	Thank you for your comment. The study was not picked up during our initial search as this was published after our search was completed. However, having examined the study, it does provide prognostic accuracy evidence in older people, for whom the evidence was limited. Based on this, the study has been included. The committee agreed that the data presented in this study supported the recommendation that people with a Chinese or other Asian family background should utilise a lower BMI cut-off for overweight/ obesity. This study found the most accurate classification of overweight began at 23 kg/m^2, and that is what this guideline has recommended for people with a Chinese or other Asian family background. Based on this finding, recommendation 1.2.8 was not amended.
University of Wolverhampton	Guideline	006	010	How to calculate or link to NHS calculator for both BMI and W:H ratio	Thank you for your comment. A link has been provided for the NHS BMI healthy weight calculator. This tool can be used to calculate BMI but also provides information on how the waist should be measured. The committee were unaware of a NHS waist-to-height ratio calculator, however recommendations have been amended to provide details on how the waist should be measured and how waist-to-height should be calculated.

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University of Wolverhampton	Guideline	006	025	Rec 1.1.11 – The suggestion of raising the topic of weight sensitively is valid but many clinicians still feel uncomfortable raising the topic due to a perceived lack of knowledge and confidence, and may therefore still avoid it. These are possible barriers to implementation of this guideline in practice. This is particularly true if weight is unrelated to the presenting complaint, so is discussion around weight still recommended in this case? Page 7, line 13-14 suggests 'adjust the approach dependent on the persons clinical need'. If presenting conditions are likely or confirmed to be as a result of obesity and central adiposity, then whilst a need for sensitivity (and positivity as noted on page 14 line 11) remains, is there a need in this instance to have the conversation. i.e., what if in asking permission to talk about the degree of overweight a patient declines? On page 14 lines 19-20 it is noted that 'The committee noted it is important for adults to know the long-term health risks and conditions associated with obesity and central adiposity.' On page 18 line 29-31 is it suggested in the context of working with a child or young person that this should be a collaborative process 'works together with their family and healthcare practitioners to make an informed decision about the treatment or care option that is best for them'. This is also the case with any patient, with this collaborative process underpinned by open, supportive	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

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				and solution focussed communications. The complexity of sensitive discussions regarding weight would suggest clearer guidelines are provided on this matter.	
University of Wolverhampton	Guideline	006	026	Define more carefully what is mean by "sensitive manner" for practitioners. I am not sure a consistent experience will be had by patients if we ask clinicians to self-determine what is 'sensitive'. Proposing preferred terms may offer more precise direction in line with what this guideline is trying to achieve. We have person first language for many other conditions. Patient engagement work we have done suggests that terms such as 'obese' are ok in a medical context, but patients would prefer to be asked. "A person living with obesity" seems to be preferred by most, and is used within the guideline (P13 20-21). Can we encourage practitioners to ask about preferred terms?	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
University of Wolverhampton	Guideline	008	11	Weight, waist and height need to be checked at least annually	Thank you for your comment. Forthcoming updates of the guideline have been planned which will examine effectiveness of interventions for identification and increasing uptake of weight management services. For further information, please refer to the scope. Your comment will be taken into consideration when conducting future updates.
University of Wolverhampton	Guideline	008	028	It will be helpful to add the range represented by the SD in brackets so that the clinician can use for quick reference.	Thank you for your comment. The committee noted that the range represented by BMI SD are not typically provided.

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					Based on stakeholder feedback, the committee highlighted that there are resources available such as educational resources produced by the RCPCH and the National Child Measurement Programme Operational Guidance which provides information on how the clinical definitions of BMI link to BMI centiles and SDs. The rationale and impact section of the guideline has been amended to highlight these resources.
University of Wolverhampton	Guideline	009	014	This can be drastic and traumatic for children and young people if the practitioners are not appropriately qualified and can push the young person towards body dysmorphia and eating disorder, we emphasise the need for referral to chartered counselling, clinical or health psychologist to start the conversation, and for a multi-disciplinary approach to child eating behaviour.	Thank you for your comment. As highlighted in the rationale and impact section of the guideline, committee did agree that discussions on degree overweight and obesity should be conducted in a sensitive and positive manner and that sensitivity is needed about the possible negative impact on children and young people with conditions such as eating disorders or disordered eating. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people.

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					Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language. The committee further noted that while it would be useful to refer children and young people to chartered counselling or to a clinical or health psychologist, such services are not readily available in practice. Additionally, the committee noted that currently there is a long waiting list for Child and Adolescent Mental Health Services (CAMHS). This means that it would not be feasible to refer children to such services. The rationale and impact section of the guideline and section 1.1.11 in evidence review B has also been amended to reference the healthier weight competency framework which also highlights that health and care staff that are involved with engaging with people about a healthier weight should be able to understand the stigma that is associated with weight, the impact this can have on people, be able to identify implications of the child or young person's weight status and be able to discuss empathically and accurately.
University of Wolverhampton	Guideline	009	016	Define more carefully what is mean by "sensitive manner" for practitioners. I am not sure a consistent experience will be had by patients if we ask clinicians to determine what is 'sensitive'. Proposing preferred	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for

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				terms may offer more precise direction in line with what this guideline is trying to achieve. We have person first language for many other conditions. Patient engagement work we have done suggests that terms such as 'obese' are ok in a medical context, but patients would prefer to be asked. Comparative phrases, e.g. larger, bigger, heavier, are not well received, likewise any language which may be belittling of the condition e.g. "big girl". "A person living with obesity" seems to be preferred by most, and is already used within the guideline (P13, 20-21). Can we encourage practitioners to ask about preferred terms?	healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
University of Wolverhampton	Guideline	011	014	Self-measurement of waist circumference may help to reduce stigma but a challenge may be the reliance on individual self-motivation to complete and report result, and do so honestly. A possible consequence could be that associated risks remain unidentified and prevention being less effective, particularly with the recommended threshold being BMI 35. An educational video could be made to help individuals with instruction on how to do this. Tape measures may also be needed by some – will these be supplied? Otherwise, we run the risk that people might guess or use a piece of string etc., which may introduce error.	Thank you for your comment. Committee agreed that motivation can present a challenge, however, it should be noted that a threshold of 35kg/m^2 was set as health risks are likely to be high and measuring waist-to-height ratio would add little to the prediction. This has been clarified in the rationale and impact section of the guideline. Additionally, recommendation 1.2.15 has been further amended to clarify level of intervention should be discussed and agreed in adults who are living with overweight or obesity or have increased health risk based on waist-to-height ratio. This implies that treatment can be offered if either criterion is met.

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					Furthermore, the rationale and impact section has been amended to highlight additional resources that are available, including tutorials on how the waist should be measured. Lastly, committee noted that in practice, equipment such as scales are not loaned out to patients which means its unlikely tape measures would be supplied. However, tape measures are accessible and inexpensive. The committee noted that while there is belief that string may be an inaccurate method of measurement, the string test (in which a sting is used to measure the height and folded in half to measure the waist) has been adopted in Thailand as well as in the UK. Section 1.1.11 in evidence review A has been amended to provide further information on how the test is used.
University of Wolverhampton	Guideline	012	019	In addition to considering muscle mass and age, height should be used as an easy guide for clinicians to start use the consideration of the BMI interpretation. Please consider that not all BAME are a smaller build. Equally, please consider point 3 above regarding the use of WHT·5R=WC/Height$^{0.5.}$	Thank you for your response. Stakeholder comments were identified which highlighted papers which examined the revised WHT.5R calculation. These papers were excluded on the basis that ethnicity was not stratified and focused on cardiometabolic risk, which did not match our review protocol. Additionally, all studies identified in the review on waist-to-height ratio, used the standard calculation of waist circumference divided by height. Based on these factors, recommendations were not changed to incorporate the revised calculation.

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					However, the committee agreed more research was important to confirm the measure's accuracy and linking it to relevant prognostic outcomes. In doing so it may become clear what a suitable boundary value would be. In addition, it is important to utilise this measure on people with a range of family backgrounds to confirm it is valid in those populations. As such it has been included in the research recommendation linked to evidence review A and referenced in the committee discussion.
University of Wolverhampton	Guideline	012	029	In "people in Black, Asian and minority ethnic", it is better to breakdown "Asian" group into "South Asian" and "Chinese and other Asian" (other Asians includes Japanese, Korean, Thai, Viennese, Nepal, etc) because of their differences in body weight and shape. The guideline should define "other Asian" group.	Thank you for your review. This review broke down the Asian ethnic group into Chinese, South Asian, and other Asian. The committee used the UK census definition in the protocol for "Any other Asian background". This definition does not list nationalities that sit within the ethnic group. The specific ethnic backgrounds covered by the included studies were already listed in in the review in the adult population. Studies exploring other Asian population included Thai, South Korean and Japanese populations. The committee agreed this group was representative of the other Asian family background and utilised the

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					data from these studies to make recommendations for people of with any other Asian person.
University of Wolverhampton	Recommendations for intervention	009	022	Although SEND is mentioned in relation to children and young people once again adults with additional support needs are overlooked and excluded. This needs to be either addressed in the research needs, or adding in. Presenting the guidance offered on page 16, 7 earlier may help.	Thank you for your comment. Based on stakeholder feedback, recommendation 1.2.7 has been amended to include a hyperlink to Public Health England guidance on obesity and weight management for people with learning disabilities. Furthermore, recommendation 1.2.15 has been amended to include special educational needs and disabilities (SEND) as a factor that needs to be taken into account when discussing and agreeing the level of intervention. The rationale and impact section has also been amended to highlight reasonable adjustments that may be required for people who are unable to get on scales independently or be lifted safely. Lastly, children, young people and adults with SEND have been included as a subgroup in the research recommendations (See appendix L in evidence review B).
Weight Watchers	Guideline	004	010	WW welcomes the clear guidance given about waist-to-height ratio and it's usefulness in assessing risk. In addition to the guidance specified about how to take the measurement, it might also be helpful to include advice on how frequently this measurement this should be taken both for people trying to lose and maintain weight.	Thank you for your comment. Further updates of this guideline have been planned which will examine identification of overweight and obesity and increasing uptake of weight management services (please refer to scope for further information). Your feedback on the frequency of measurements will be

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					considered during forthcoming updates of this guidance.
Weight Watchers	Guideline	005	002	The cautions about BMI raised here and at other points in the guidance are very helpful. In addition to helping to reduce stigma but also it offers a helpful tool for people who are ambivalent about the use of BMI.	Thank you for your comment.
Weight Watchers	Guideline	005	020	The advice to use clinical judgement to interpret health risk/central adiposity and then use waist-to-height ratio, rather than relying solely on BMI, is a useful addition. Will this therefore result in a change to the criteria used to identify eligibility for weight management services with waist-to-height ratio accepted as a valid inclusion criteria ? It would be unfortunate if an at risk person excluded based on BMI	Thank you for your comment. The committee agreed that health risks as well as BMI are important to take into consideration when discussing and agreeing level of intervention. Based on stakeholder feedback, the committee amended recommendation 1.2.15 to state that level of intervention should be discussed and agreed with adults who are living with overweight or obesity or have increased health risk based on waist-to-height ratio.
Weight Watchers	Guideline	006	020	WW welcomes the clear public health message of 'Keep your waist to less than half your height.' However, this does need to be linked to a call to action, and access to interventions if clinically indicated.	Thank you for your comment. Recommendations 1.2.15 and 1.2.16 do highlight steps that need to be taken when considering interventions for people identified as high risk.
Weight Watchers	Guideline	006	025	Advising HCP's to ask a patient's permission before talking about weight is helpful. We would welcome clear guidance and signposting to resources that can help with this (as in mentioned on p.19 in discussing with children, young people and their carers). Alongside this we would ask that HCP's are supported and encouraged to actually raise the issue of weight,	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people.

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				with signposting to evidence-based resources on how to do this, for example the BWEL brief intervention, Aveyard, P., Lewis, A., Tearne, S., Hood, K., Christian-Brown, A., Adab, P., Begh, R., Jolly, K., Daley, A., Farley, A. and Lycett, D., 2016. Screening and brief intervention for obesity in primary care: a parallel, two-arm, randomised trial. *The Lancet*, *388*(10059), pp.2492-2500.	Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
Weight Watchers	Guideline	006	027	Whilst WW welcomes the note of caution in interpreting BMI in people older than 65, it would be helpful to give some advice on upper BMI or waist ratio cut offs. Given the reluctance of HCP's to raise the issue of weight in the general population, this point is potentially open to misinterpretation with overweight/obesity being further ignored or avoided in older populations (who may already experience health inequalities due to the age stigma).	Thank you for your comment. The committee noted that the clarification around the use of BMI in older people was essential as this measure does not capture changes that occur in the body due to aging. Additionally, limited evidence was identified in the older population, which meant that the committee were unable to drafted further recommendations on how BMI should be interpreted in older people. To facilitate further research in this population, the committee have listed older people as an important subgroup in the research recommendation. Appendix L in evidence review A has also been amended.
Weight Watchers	Guideline	009	014	We would request that point 1.2.6 is moved to p.8 line 26 to reinforce the primary importance of patient-centred collaborative care. We would ask that advice on raising the issue of weight sensitively, is added in addition to advising discussions on the impact of the degree of overweight, obesity and adiposity once measurement has been completed.	Thank you for your comment. Forthcoming updates of this guideline have been planned that will further examine effectiveness of interventions to identification and increasing uptake of weight management services. For further information, please refer to the scope. Your comment will be

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					taken into consideration when conducting future updates. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.
Weight Watchers	Rationale	011	013	Following on from the rationale underpinning the advice that individuals use waist-to-height ratio to measure themselves and interpret the results, will there also be a recommendation that if there is a local weight management service people should be able to self-refer based on BMI and/or waist-to-height ratio? Asking a person living with obesity to seek advice, rather than being able to directly self-refer, puts additional barriers in the way of treatment. This maybe particularly the case for those individuals who have experienced weight stigma within the health system. This also would enable faster referrals and reduce the burden on HCP's.	Thank you for your comment. Forthcoming updates of the guideline have been planned which will examine effectiveness of interventions for identification and increasing uptake of weight management services. For further information, please refer to the scope. Your comment into consideration when conducting future updates.

Obesity: identification and classification of overweight and obesity (update)

Consultation on draft guideline - Stakeholder comments table
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Weight Watchers	Rationale	012	016	WW endorse this recommendation and would also add that the addition of waist-to-height ratio to the guidance is underpinned by evidence-based BCT principles of self-monitoring and building self-efficacy. It also has potential benefits to wellbeing for people who have a difficult relationship with weighing scales.	Thank you for your comment.
Weight Watchers	Rationale	014	007	WW agree that the waist-to-height public health message is clear but as it is a call to action would be benefit from further clarity on what people who are at risk are to do with this information.	Thank you for your comment. Recommendation 1.2.2 does state that people should seek advice and further clinical assessments from a healthcare professional if they have identified themselves as having increased health risk.
Weight Watchers	Rationale	014	014	The advice of being sensitive to the impact on people with eating disorders and disordered eating would benefit from further clarification. There is a general under recognition of binge eating disorder as an eating disorder both amongst HCP's and the general population. Anorexia and bulimia are often thought of as the main eating disorders, whilst of course binge eating disorders and disordered overeating behaviours effect a far higher percentage the population (Harris, S.R., Carrillo, M. and Fujioka, K., 2021. Binge-eating disorder and type 2 diabetes: A Review. *Endocrine Practice*, *27*(2), pp.158-164.) Further clarification of disordered eating would be beneficial, for example naming emotional and comfort eating.	Thank you for your comment. The rationale and impact section in the guideline has been amended to provide clarification on eating disorders and disordered eating. Additionally, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.

Obesity: identification and classification of overweight and obesity (update)

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Weight Watchers	Rationale	014	026	In addition HCP's and patients reaching a shared decision about intervention, there is a need to ensure that initial and follow up support are offered to avoid distress and improve wellbeing. Identification needs to be supported by evidence-based treatments that goes beyond generic advice to lose weight/eat less, exercise more.	Thank you for your comment. The focus of this update was on identifying and assessing overweight and obesity in adults, children and young people. Further updates of this guideline will examine weight management programmes in children and young people. For further information, please refer to the scope.
Weight Watchers	Rationale	015	023	Whilst WW agree that an increase in cost is likely to be offset by the better health outcomes, this will only by the case if people know what to change, how to change it and are supported in making changes with evidence-based treatments, which could be reiterated here.	Thank you for your comment. CG189 does include recommendations on lifestyle and behavioural interventions, physical activity, dietary and pharmacological interventions which have developed based on evidence. This update will also involve the amalgamation of 8 different guidelines, which will include recommendations on weight management programmes for adults. As part of the update, further work has also been planned which will look at the effectiveness of different diets for adults, and effectiveness of healthy living and weight management programmes for children and young people. For further information, please refer to the scope.
Weight Watchers	Rationale	019	008	It is helpful that the Committee have been able to identify some specific training programmes that can support HCP conversations with children and young people about weight. It would be beneficial if they could add similar recommendations for adults, or if	Thank you for your comment. Based on stakeholder feedback, the rationale and impact section of the guideline has been amended to highlight the resources and training programmes available for healthcare professionals to gain further knowledge

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				they consider that there is not adequate provision or evidence currently in this area, consider adding this as a research recommendation (p. 10) to help drive research funding.	on stigma and how to discuss degree of overweight and obesity with adults, children and young people. Future updates have also been planned for this guideline where we will further consider the issues around weight stigma and using sensitive language.