Weight management – Stakeholder workshop discussion:

Thursday 11th March 2021

Area of scope	Stakeholder views
Scope: overall impression **Does the scope make sense?** **Overall, do we have the right focus?**	Stakeholders welcomed that NICE were amalgamating the obesity guidelines. However, they did note that it is a large undertaking and that the individual guidelines are already lengthy. They suggested that the guidelines could be split into two, for example, management and prevention could be separate guidelines. Others suggested that obesity and weight management should be treated differently. The general consensus was that having all obesity guidelines in one place would be helpful to access obesity guidance. Stakeholders said that a blanket approach to obesity would not be suitable for everyone. There are people who need a difference in care. These people must be identified and have tailored management. Stakeholders highlighted that there should be an emphasis on whole body health and healthy living rather than targeting weight alone. Mental health is tied to overall health and quality of life. Enacting change with a view to make people's physical health better can have a detrimental effect on mental health. Therefore, people should be assessed for suitability for different interventions, so the

	change is manageable and the improvement in quality of life is seen across the person's whole health. Stakeholders wanted the guideline to link the personal responsibility of weight management with the wider societal architecture to give obesity policy the best chance of improving people's lives. Stakeholders said that they liked: • The focus on prevention. • Individual interventions instead of only a societal approach as they thought that outcomes are achieved faster. Stakeholders suggested that the following should be considered: • Surgical interventions • Pharmacological interventions • Considerations for different populations, for example safeguarding for children • Pre-diabetes • Behavioural changes • Mental health disorders

	• Weight exhaustion Stakeholders said that there is a large amount of evidence for management in children that is unlikely to meet NICE inclusion criteria. This could mean that the guideline could be out of date very quickly.
Section 2: Who the guideline is for This guideline is for: • healthcare professionals • commissioners and providers • people who work in the wider public, private, voluntary and community sectors • people using services, their families and carers and the public. **Is there anyone else this guideline should be for?**	The stakeholders commented on the broadness of the groups listed. Some suggested that specific groups should be listed so people know if they are included or not. But generally, stakeholders felt that keeping the breadth is important as to highlight it is everyone's responsibility. Stakeholders said it was important to include Royal Colleges, local authorities, and local government.
Section 3.1 Who is the focus? The population • People aged over 2 years living with obesity or overweight and those who currently have a healthy body weight. Specific consideration will be given to	Stakeholders were concerned that the blanket approach may risk not capturing specific groups. For example, prevention in working populations vs workplace interventions. Stakeholders said that the terms "healthy body weight" and "normal" may not be the most useful. It could say "normal body weight according to NICE guidelines"

• Black, Asian and minority ethnic groups. • People from lower socioeconomic groups. • Children and young people, and their families or carers. • People with a learning disability. • People with a physical disability. • Older people. • People with mental health problems. • People with type 2 diabetes. **Are the inclusions from the scope correct?** **Are there any groups we should give specific consideration to?** The guideline will not cover: • People whose body weight is below the healthy range (underweight). • Pregnant women. • Children under 2 years old. **Should women who are breastfeeding be included or excluded?**	or "classified as normal weight". Many people who believe they are a healthy body weight do not identify they are living with overweight or obesity. Stakeholders provided the following suggestions for populations needing specific consideration: • Populations who have undergone NHS health checks. • Type 2 diabetes-related conditions (pre-diabetes, historical gestational diabetes, family history of diabetes). • People with polycystic ovary syndrome. • People with thyroid function disorders. • People with vitamin D deficiency. • People with severe mental health problems. • People who have had bariatric surgery in the past. • Health workers. • People in normal BMI range with central obesity. • Pregnant women, women of childbearing age who are trying to conceive and their partners, and mothers who need bariatric surgery. • People with eating disorders. • People with long covid complications or who had severe covid – stakeholders said there was unlikely to be evidence in this area.

Are there any other groups we should exclude?	• Men Stakeholders said that there was a specific skill set required to work with certain groups. They expressed that many people working in weight management services do not have the specialist knowledge for working with people with learning disabilities or mental health problems. Because of this they question whether they are the best placed to work with people with these issues and that this is a barrier to accessing weight management services for these groups. Stakeholders discussed the variation within the populations identified as needing specific consideration. For example, when interventions target children, parents and family also need to be taken into account. In addition, the system makes families and carers less important after people turn 18 but family is an important consideration for all people. People with physical disabilities were also identified as a group with variability. They said that some people have physical impairments but do not consider themselves to have a disability, even if this could still affect obesity and weight management. Stakeholders said that older people are also a very diverse group. Some are very healthy and living in the community and others are not healthy and living in care

	homes. They also added that there is little information on obesity in care homes even though it is an important issue. Stakeholders said that people with mental health problems covers a range of people who receive care in different settings. Therefore, people with severe mental health problems should be identified as a specific group. ***Breastfeeding, and pre- and post-partum women*** Stakeholders agreed that pregnant women should be excluded as they are part of a different care pathway at that time. Stakeholders discussed whether women in the pre-pregnancy and post-partum period should be included. They discussed that post-partum care is often in tier 3 where care, including weight management, would be in a different setting and delivered by different people compared to the general population. They debated breastfeeding and the weaning period (around 6 months post-partum) but there was disagreement around whether this period should be included or not. They were aware of the benefits of weight management but did not want women to undergo drastic changes to diet and weight during this time. Concerning preconceptual care, stakeholders highlighted the importance of preconceptual care for women and their partners. They mentioned polycystic ovary syndrome and the higher incidence of obesity in that group.

	Suggestions for exclusion Stakeholders agreed that it was right to exclude under-2s from general population as they would have different approach. Stakeholders identified patients with obesity and active cancer and people undergoing bariatric surgery prior to cancer surgery. Weight management for these groups is different therefore they should be either excluded or identified as a separate group.
Section 3.2 Settings The guideline will cover: • All settings where publicly funded services are provided. • Early years settings, including nurseries and childcare facilities. • Schools providing primary and secondary education. **Are there any other settings that should be included?** **Are there any settings that should be excluded?**	Stakeholders thought the following settings should be covered: • Workplace • Universities • Special schools • Outsourced services such as Weight Watchers • Voluntary services • Non-publicly funded care • Self-monitoring equipment used at home Stakeholders debated whether publicly funded services should be stated specifically. For example, primary care for prevention and detection, and community pharmacies that can identify people who are at risk. They also mentioned residential services, elderly, settings involving people with learning

	disabilities, settings that care for people with long-term mental health problems, prisons, hospitals, and care homes.
Section 3.3 Activities, services or aspects of care and Section 3.5 Key issues and questions. **We are proposing this guideline will cover 4 areas:** • Identification and assessment. • Individual-level approaches for prevention of excess weight, weight loss, and maintaining a healthy weight. We will retain and amalgamate existing recommendations in the areas below when developing this update: • Whole-system approaches. • Care pathway and service delivery. **Any comments?**	***Areas in the guideline*** Regarding the areas drafted for update, the stakeholders were concerned that tier 3 and 4 were not considered. They said that more evidence on bariatric surgery and pharmacological interventions had been published since the last update of the obesity guidelines. In particular, identifying and fast-tracking people who would most benefit from surgery from primary care. Stakeholders were reassured when they were told that NICE was aware of the new evidence, but it would not change the current recommendations and that pharmacological interventions were covered by Health Technology Appraisals. Stakeholders commented on new evidence of cognitive behavioural therapy CBT that could be reviewed. Stakeholders noted that long term data is important in weight management and maintaining weight loss. Most people's experiences of weight loss are not a continuous weight loss process leading to a healthier weight that is maintained indefinitely. In addition, many trials are short term and do not reflect people's real-life experiences of weight management. Therefore, what maintaining weight loss means and the time horizons are considered important in this guideline.

We have drafted the following questions to consider Identification and assessment 1.1 What is the most accurate method of measuring the health risk associated with overweight and obesity, including adiposity, in adults? 1.2 What is the effectiveness of opportunistic proactive identification of overweight and obesity in adults from black, Asian and other minority ethnic groups in improving health outcomes? **Are these the correct questions for this area?** **Any comments?** We have drafted the following questions to consider Individual-level approaches for prevention of excess weight, weight loss, and maintaining a healthy weight 2.1 What physical activity interventions are effective in achieving weight loss and maintaining a healthy weight in adults living with overweight or obesity?	Stakeholders mentioned people could be identified in the workplace through occupational health. They also said there is evidence associating shift-work and obesity. This should be considered in prevention. Stakeholders commented on the complexities of obesity. They identified the individual and societal narrative of the condition, as well as the individual responsibility and societal architecture from which obesity is formed. They said it is important to assess the bigger picture. Stakeholders were reassured that the tier system and organisation of services is covered by Public Health England and NHS England's remit. Stakeholders said that when managing weight, the focus should be on people's health and not aesthetic considerations. ***Draft questions*** **Question 1.1** Stakeholders welcomed the question to look at measures to screen, measure, and monitor obesity other than BMI. They stressed the importance of whole-body health rather than height/weight measures, such as height to waist circumference. Doing this means considering a combination of factors to assess people's risk and then progress. They should be accurate but also be easy enough to use in clinics and not be overcomplicated or too technical to use. This

2.2 What is the effectiveness of total or partial diet replacements in achieving weight loss in adults living with overweight or obesity? 2.3 Which physical activity interventions and behaviour change techniques are effective, alone or in combination, in helping children and young people who are living with overweight or obesity achieve and maintain a healthy weight, as part of a weight management programme? 2.4 Which weight management programmes are effective at preventing overweight or obesity in children aged 2 to 5 years? 2.5 Which weight management programmes are effective at preventing overweight or obesity in children and young people aged over 5 years?	will allow better communication to people and aid in prevention. Stakeholders said that differentiating between overweight and obesity was important to allow appropriate tailoring during management. However, there was also a call to move away from hard cut-offs and moving towards staging. Stakeholders also said that measures should be easy enough for people to complete at home so people can self-monitor. This can overcome the problem of not being able to assess people in person posed by an increase in telephone consultations. Stakeholders provided the following measures that could be used to measure obesity: • Adipose Based Chronic Disease • King's Obesity Staging Score • Edmonton Scale Stakeholders mentioned the importance of assessing people's psychological state and their propensity to change during the weight management journey. Stakeholders identified barriers to measuring obesity and communicating results to people. Barriers they noted include: differences in beliefs around weight between ethnic and socioeconomic groups; taboos and stigma around weight management; some mental health problems make it difficult to measure and communicate risk to people. Stakeholders said evidence needs to be assessed

2.6 What approaches are effective in helping children aged 2 to 5 years, who are living with overweight or obesity achieve and maintain a healthy weight as part of a weight management programme? 2.7 How effective are parent-only behavioural weight management programmes in helping children, aged 2 to 12 years, who are living with overweight or obesity achieve and maintain a healthy weight? **Are these the correct questions for this area?** **Any comments?** **These are the areas we are proposing the guideline will address, is there anything else we should consider?** • **Digital interventions are covered in NG183 Behaviour change: digital and mobile health interventions and will be cross-referred to from the obesity guideline. Is there evidence for**	around the best way to approach these barriers and that different groups need to be represented. **Question 1.2** Stakeholders said that knowledge has advanced in terms of BAME risk for obesity. Cut-off points for increasing risk may be lower than currently stated in the guideline, particularly for South Asian communities. Stakeholders commented that the scope is not clear what thresholds NICE is using for people from different Asian populations. They also queried whether thresholds change for children in different black, Asian or other minority ethnic groups. Regarding opportunistic, stakeholders said that there needs to be a firmer stance on health practitioners screening for obesity. The wording, “opportunistic” can make many healthcare practitioners feel uncomfortable approaching people on the topic. It means they avoid the topic as they are cautious about offending patients especially in BAME groups. Stakeholders questioned whether screening should be opportunistic or part of standard care. Therefore, all staff should be armed with communication skills to deal with those steps. Stakeholders were concerned about implementing new strategies but a new policy push towards management of weight management services should help this.

using digital interventions in combination with other therapies? • **Should intermittent fasting be considered as a diet intervention?** **We are not proposing to update any recommendations under whole-systems approaches or care pathway and service delivery. Are there any recommendations that should be updated in these areas?** **Are there any recommendations from any of the guidelines that should be removed and not included in the new guideline?**	Stakeholders were concerned about the level of awareness in the health community surrounding obesity. Many do not have specific training and therefore lack the communication skills necessary to bring up opportunistic screening. ***Section 2*** Stakeholders commented on the terminology used in the draft questions. They suggested that "healthier weight" or "maintaining weight loss" is better than focusing on achieving a BMI of below 25. They also said that a healthy living programme is a more accurate description, instead of a weight management programme. Stakeholders spoke about the importance of habit formation when changing people's behaviour. They commented on the language of the questions, which they said were too clinical for behavioural topics. People understand habits better and by framing it as habitual change it allows people to take more personal responsibility over their own actions. A "one change approach" to behaviour was mentioned to bring focus to people's triggers. Stakeholders also wanted to note that developing a good relationship with food is important to changing behaviour. This allows the person to enjoy food in a healthy way by training them to identify true hunger and satiety. It also recognises external and internal triggers to work with.

	As well as behaviour change, stakeholders wanted behaviour support to be included in the scope as they said a support network and peer group support are important in weight management. Stakeholders brought attention to the structure of tier 3 and 4 services, which are listed differently in NICE to what they are by NHS England. **Questions 2.1 and 2.3 (physical activity)** Stakeholders noted that for some people completing 60-90 minutes of physical activity a day, as recommended in CG189, may not be feasible. There is evidence that high intensity for short periods is better for weight loss. They mentioned that the guideline should assess tailoring physical activities to level of overweight or obesity. This is because the activity should be sustainable to support weight loss. This also applies to people who have physical disabilities, and appetite or energy considerations, which can limit their physical activity. Stakeholders commented on the distinction between physical activity and reducing sedentary time. They suggested the wording of the draft questions could incorporate reducing sedentary time. Stakeholders said that physical activity should be reframed as a behaviour change technique, although it is the weakest way to address weight management. This is part of the whole human thinking about weight loss and

	may affect how care pathways are implemented. They also asked that specifics on which physical activity interventions are being recommended. **Question 2.2** Stakeholders agreed that long term effectiveness was important. However, they pointed out that there may be instances where short term effectiveness is an important consideration. An example was given where short term weight loss to qualify for knee surgery will enable long term increase in exercise. They said that the focus should not detract from the usefulness of interventions that may only have short term effect. Stakeholders commented that the question was limited in scope and appeared that the only other option was physical activity. Suggestions for other diets included plant-based, low-carb and intermittent fasting. On the topic of intermittent fasting, stakeholders said there was a lot of evidence about intermittent fasting but urged caution. The understanding in the general public is different to what the evidence demonstrates, and the term is used incorrectly. They mentioned people fasting for days because of an app that encourages people to fast for as long as possible. If the guideline recommends intermittent fasting, it needs to have a clear definition and to be clear on how long the fasts should last.

	Questions for children and young people (2.4 to 2.7) Stakeholders commented on the age ranges in the questions. They said that the guideline might need to consider age differently and suggested: pre-school, pre-teen, post-teen, or split into primary and secondary school age. There are behavioural differences in these age groups, settings for these groups will be different and literature is likely to address these age groups differently. Stakeholders questioned why children would be in a weight management programme if they are not overweight or obese. To address this, they suggested the setting might be better as schools. Stakeholders questioned why 2.7 was capped at 12. They were reassured that it was based on evidence provisionally identified during surveillance and scoping. Stakeholders wanted to ensure that parent-only interventions meant interventions that were delivered by trained individuals with the parents as the target of the intervention, and not solely parents delivering the intervention to children. ***Areas not included in draft scope*** Stakeholders suggested the following topics should be included: • Vitamin D deficiency, association with ethnic groups and obesity and comorbidities. • Stigma.

	• Digital interventions (see below). • Mental health interventions. • Functional physical activity and activities of daily living. • Microbiome association with weight. • Quality over quantity. • Who is doing the identification/assessment. • Complementary therapies. ***Digital interventions*** NICE recognises there is scope to include interventions delivered through digital means, such as over video call, and asked stakeholders on their views. These are different to the wholly automatic digital interventions covered in NICE guideline NG183 Behaviour change: digital and mobile health interventions. Stakeholders welcomed this consideration. They recognised that many interventions are delivered by people, but virtually. Therefore, these should be looked at. Stakeholders suggested that the interventions could be optimised or specific to certain tasks, for example monitoring. This could then feed into a low-labour national registry but also prepare people for different interventions or remind them to do certain tasks.

	Whole systems approach Stakeholders commented that local authorities have not adopted a whole systems approach as they invest a significant amount of money and get little in return. Stakeholders said that a joined-up approach is a better way of working. They said that weight management services should be adopted by local authorities otherwise they may continue to be ineffective. Stakeholders said that the audience for NICE guidelines should be beyond clinicians and patients. ***Recommendations to remove*** Stakeholders highlighted the recommendation saying a 600-calorie deficit is needed, but it has been oversimplified by clinicians to "eat less, move more". Stakeholders suggested the recommendation should be updated to provide nuance.
Section 3.6 Main outcomes The scope has listed the following outcomes, these are broad to allow the committee to consider which outcomes they would like to look at for each question. • mortality • morbidity (for example, progression of type 2 diabetes or cardiovascular disease)	Stakeholders suggested the following outcomes: • Experience measures (PREMs measures) about how patients perceived programmes. • Change to diet quality. • Standardised scales for eating behaviours. • Assessment of testosterone levels as there is an association with testosterone and obesity.

• change in weight (for example, percentage weight loss or changes in BMI or waist circumference) • maintenance of weight loss in the short, medium and long terms • intermediate outcomes (for example changes in diet and physical activity level) • health-related quality of life • adherence (for example, dropout rates) • adverse events • cost effectiveness. **Are these the right outcomes?** **Are there any outcomes you think the committee should specifically consider?**	• Screening for biochemical elements that influence obesity/fat deposits e.g. subclinical hyperthyroidism. • behavioural outcomes changes in mental attitude perception of themselves. These should be more specific than what is covered under quality of life measures. • Long-term impact and tracking changes in eating patterns especially for children. • Morbidity – the committee asked if there will be a list provided. • Confidence in self-managing after treatment has ended. • Number of people who get referred back to services. • Change in adiposity instead of change in weight.
Equalities Potential equality issues to consider during the development of this guideline: Age, disability, race, sex, socioeconomic factors and other health conditions **Please raise any issues that you identify as being relevant to the equalities theme.**	Stakeholders suggested the following groups had potential equality issues to consider for this guideline: • Inequities in access, for example availability of tier 3 services. • SES and related geographies. • LGBT+

Scope in general: **Are there any other comments on the scope?**	Stakeholders said that the definition of tier 3 is open to interpretation. In addition, services need to be joined up, for example people looking to stop smoking have to seek support from GP and it sits outside tier 3. The same occurs when people with eating disorders are dealt with in weight management, the service is separate. NICE reminded stakeholders that national policy is outside of NICE's remit.
Guideline committee composition We are proposing to recruit the following members for the committee: • Weight management service provider • Psychology, psychiatry specialising in behavioural weight management • Exercise programmes specialist • Paediatric weight management specialist • Lay members x 3 – person living with overweight, person living with obesity, and person with a weight-linked health condition • Public health practitioner • Local Authority commissioner • GP or Practice Nurse • Specialist dietitian • Expert in obesity-related health inequalities • Topic expert on learning disabilities.	Stakeholders suggested the following roles should be considered for committee recruitment: • Psychologist • Psychiatrist • Specialist dietician (expert in obesity/weight management) • Registered nutritionist • A generalist expert on obesity • Expertise in bariatric surgery • Lay member who has had bariatric surgery • Early years health professional • Physiotherapist • Paediatrician

Should we recruit any other roles either as a committee member or a co-opted expert?	• Occupation health • Wellbeing professional • Community pharmacist • Specialist in Type 2 diabetes • Patient representation • Commercial weight loss industry representative e.g. weight loss groups • Charity representative • Include people working with adults, under 5s, older children and families • Mental health expert • NHS commissioner • Local authority commissioner • Digital provider • Someone who has successfully maintained a healthy body weight over time • Care home provider • Lay members • Exercise programme specialist • Health visitor

	• Midwife Potential topic experts or co-opted were identified as: • Expert on physical disabilities • Expert from a weight management guideline that has been successful from outside the UK • Expert in stigma